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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation and Petition to Revoke Probation Against: ROBERT NORFLEET EDWARDS, M.D. Linkville Medical Laboratories 4509 S. 6th Street, Suite 311 Klamath Falls, OR 97603 Physician's and Surgeon's Certificate No. C39176 Respondent.	Case No. D1-1999-103134 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about April 15, 1980, the Medical Board of California ("Board") issued Physician's and Surgeon's Certificate No. C39176 to Robert Norfleet Edwards, M.D., Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2010, unless renewed. A certified copy of Respondent's license history is attached hereto as Exhibit 1.

2. On or about December 1, 2006, the Board issued a Decision After Remand From Superior Court ("Decision After Remand") which became effective on December 31, 2006 with the following special terms and conditions: Revocation stayed; five years probation;

condition precedent of successful completion of the equivalent of the Physician and Assessment and Clinical Education Program (PACE) offered at the University of California – San Diego School of Medicine; and, successful completion of a medical record keeping course within the first six months of probation; a practice monitor or Board-approved equivalent. A true and correct copy of the Decision After Remand is attached as Exhibit A to Exhibit 2, the Accusation and Petition to Revoke Probation.

3. On or about April 8, 2008, the Board issued a Notice of Out of State Suspension Order to Respondent. The Physician's and Surgeon's Certificate No. C39176 is currently in suspended status, based on full license restrictions pursuant to section 2310(a) of the Business and Professions Code.

4. On or about May 27, 2008, Complainant Barbara Johnston, in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, filed Accusation and Petition to Revoke Probation No. D1-1999-103134 against Robert Norfleet Edwards, M..D. (Respondent) before the Medical Board of California.

5. On or about May 27, 2008, Arlene Krysinski, an employee of the Board, served by Certified Mail a copy of the Accusation and Petition to Revoke Probation No. D1-1999-103134, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, 11507.7, and 11455.10 to Respondent's address of record with the Board, which was and is: Linkville Medical Laboratories, 4509 South 6th Street, Suite 311, Klamath Falls, OR 97603. A copy of the Accusation and Petition to Revoke Probation, the related documents, and Declaration of Service are attached hereto as Exhibit 2, and are incorporated herein by reference.

6. The allegations of the Accusation and Petition to Revoke Probation are true as follows: On or about February 7, 2008, the Oregon Medical Board, State of Oregon (Oregon Board) issued a Final Order whereby Respondent's license to practice medicine in Oregon was revoked. The Oregon Board's action, which followed a hearing, made findings that respondent had demonstrated numerous departures from the standard of practice in several areas of his practice and had failed to demonstrate to the Oregon Board his ability to practice medicine

safely by failing to the meet the requirements imposed on him as a result of a 2003 Order from the Oregon Board which placed respondent on probation for five years subject to conditions. In particular, the Oregon Board found that respondent did not meet the standard of care in his forensic medicine practice in 19 out of the 20 autopsy reports reviewed, and that respondent was repeatedly negligent in his nuclear medicine practice as shown by the numerous nuclear medicine cases reviewed. Attached to the Accusation and Petition to Revoke Probation (Exhibit 2) as Exhibit B is a true and correct certified copy of the Oregon Board's Final Order dated February 7, 2008.

7. Service of the Accusation and Petition to Revoke Probation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c).

8. On or about June 4, 2008, the Board received the green certified receipt card from the U.S. Postal Service which was signed and dated on 5/30/2008 by an agent of Respondent. A copy of the signed green certified receipt card returned by the post office as proof of delivery is attached as Exhibit 3, and is incorporated herein by reference.

9. Business and Professions Code section 118 states, in pertinent part:

"(b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the license on any such ground."

10. Government Code section 11506 states, in pertinent part:

"(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing."

11. Respondent failed to file a Notice of Defense within 15 days after service upon him of the Accusation and Petition to Revoke Probation, and therefore waived his right to a hearing on the merits of Accusation and Petition to Revoke Probation No. D1-1999-103134.

12. California Government Code section 11520 states, in pertinent part:

"(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent."

13. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on Respondent's express admissions by way of default and the evidence before it, contained in Exhibits 1, 2 and 3, finds that the allegations in Accusation and Petition to Revoke Probation No. D1-1999-103134 are true.

DETERMINATION OF ISSUES

1. Based on the foregoing Findings of Fact, Respondent Robert Norfleet Edwards, M.D. has subjected his Physician's and Surgeon's Certificate No. C39176 to discipline through unprofessional conduct within the meaning of Business and Professions Code sections 2305 and 141(a).

2. A copy of the Accusation and Petition to Revoke Probation with its attached Exhibits, related documents and Declaration of Service are attached hereto as Exhibit 2 and are incorporated herein as if fully set forth.

3. The Medical Board of California has jurisdiction to adjudicate this case by default.

4. The Medical Board of California is authorized to revoke Respondent's Physician's and Surgeon's Certificate based upon the following violations alleged in the Accusation and Petition to Revoke Probation:

a. The action by the State of Oregon Medical Board whereby Respondent's license to practice medicine was revoked, as set forth in the Final Order

(Exhibit B to the Accusation and Petition to Revoke Probation attached hereto as Exhibit 2,) constitutes unprofessional conduct and/or grounds for disciplinary action within the meaning of Business and Professions Code section 2305 and/or section 141(a).

b. The action by the State of Oregon Medical Board whereby Respondent's license to practice medicine was revoked, as set forth in the Final Order (Exhibit B to the Accusation and Petition to Revoke Probation attached hereto as Exhibit 2,) constitutes a violation of the terms of Respondent's probation and therefor grounds for a revocation of probation and issuance of the disciplinary order that was stayed, i.e. the revocation of Respondent's certificate to practice medicine in California.

ORDER

IT IS SO ORDERED that Physician's and Surgeon's Certificate No. C39176, heretofore issued to Respondent Robert Norfleet Edwards, M.D., is revoked.

Respondent shall not be deprived of making a request for relief from default as set forth in Government Code section 11520(c) for good cause shown. However, such showing must be made in writing by way of a motion requesting to vacate the default decision and stating the grounds relied on that is directed to the Medical Board of California at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815 within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on September 3, 2008.

It is so ORDERED August 4, 2008

FOR THE MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation and Petition to Revoke Probation Against: **ROBERT NORFLEET EDWARDS, M.D.,** Linkville Medical Laboratories 4509 South 6th Street, Suite 311 Klamath Falls, OR 97603 Physician and Surgeon's Certificate No. C39176 Respondent.	**Case No. D1-1999-103134** **ACCUSATION AND PETITION TO REVOKE PROBATION**

The Complainant alleges:

PARTIES

1. Complainant, Barbara Johnston is the Executive Director of the Medical Board of California (hereinafter the "Board") and brings this accusation solely in her official capacity.

2. On or about April 15, 1980, Physician and Surgeon's Certificate No. C39176 was issued by the Board to Robert Norfleet Edwards, M.D. (hereinafter "respondent"). Respondent's certificate expires on January 31, 2010, however, the certificate is in a suspended

status based on a full out of state suspension order of no practice issued on April 8, 2008, pursuant to section 2310(a) of the Business and Professions Code. Prior disciplinary action was taken against respondent's certificate as follows: On June 28, 2004, an accusation was filed against respondent, and on April 11, 2005, a decision became effective which read: Revoked. On December 31, 2006, a Decision After Remand from Sacramento Superior Court became effective which read: Revoked, stayed, prior condition, five years probation with terms and conditions. A true and correct certified copy of the Board's Decision After Remand From Superior Court (hereinafter "Decision After Remand") which became effective December 31, 2006, is attached hereto and incorporated herein as Exhibit A.

JURISDICTION

3. This accusation is brought before the Medical Board of California, Department of Consumer Affairs (hereinafter the "Board"[1]), under the authority of the following sections of the California Business and Professions Code (hereinafter "Code") and/or other relevant statutory enactment:

A. Section 2227 of the Code provides in part that the Board may revoke, suspend for a period of not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act, and may recover the costs of probation monitoring if probation is imposed.

B. Section 2305 of the Code provides, in part, that the revocation, suspension, or other discipline, restriction or limitation imposed by another state upon a license to practice medicine issued by that state, that would have been grounds for discipline in California under the Medical Practice Act, constitutes grounds for discipline for unprofessional conduct.

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1. Cal. Bus. & Prof. Code section 2002, as amended and effective January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in the State Medical Practice Act (Cal. Bus. & Prof. Code, sections 2000, et seq.) means the "Medical Board of California," and references to the "Division of Medical Quality" and "Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

C. Section 141 of the Code provides:

"(a) For any licensee holding a license issued by a board under the jurisdiction of a department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or by another country shall be conclusive evidence of the events related therein."

"(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by the board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country."

4. Respondent is subject to discipline within the meaning of section 2305 and/or section 141of the Code as more particularly set forth herein below.

I. FIRST CAUSE FOR DISCIPLINE

(Discipline, Restriction, or Limitation Imposed by Another State)

5. On or about February 7, 2008, the Oregon Medical Board, State of Oregon (Oregon Board) issued a Final Order revoking respondent's license to practice medicine in Oregon. The Final Order, which followed a hearing, made findings that respondent had demonstrated numerous departures from the standard of practice in several areas of his practice and had failed to demonstrate to the Oregon Board his ability to practice medicine safely by failing to the meet the requirements imposed on him as a result of a 2003 Order from the Oregon Board which placed respondent on probation for five years subject to conditions. In particular, the Oregon Board found that respondent did not meet the standard of care in his forensic medicine practice in 19 out of the 20 autopsy reports reviewed, and that respondent was repeatedly negligent in his nuclear medicine practice as shown by the numerous nuclear medicine cases reviewed. The Oregon Board concluded the following:

"...[respondent's] consistent failure to conduct the necessary microscopic and toxicological studies, even with evidence of possible infectious diseases, myocardial infarction or suspected drug overdose (or to report such studies), highlight once again Licensee's propensity to practice medicine in a slip shod fashion. The Board's effort to protect the public by placing Licensee on probation has failed. The only way to adequately protect the public is to remove Licensee from the practice of medicine."

Attached hereto as Exhibit B and incorporated by reference is a true and correct copy of the Final Order of the Oregon Board dated February 7, 2008.

6. The discipline imposed by the Oregon Board constitutes a violation of section 141 and/or section 2305 of the Code and constitutes unprofessional conduct and/or a basis for the imposition of discipline.

II. CAUSE FOR REVOCATION OF PROBATION

7. The allegations and charges of the First Cause of Disciplinary Action are incorporated herein as if fully set forth.

8. Pursuant to the Medical Board's Decision After Remand issued December 1, 2006, and attached hereto as Exhibit A, under Conditions 6 and 10 of respondent's probation order, respondent was, among other things, required to obey all federal, state, and local laws.

9. As set forth in paragraph 7 above, respondent violated Conditions 6 and 10 of his Medical Board probation order by failing to obey all laws in that respondent was disciplined in February of 2008 by the Oregon Board and had his license revoked by the Oregon Board which constitutes unprofessional conduct pursuant to section 2305 of the Code.

10. Pursuant to the terms of the Decision After Remand, if respondent violates probation in any respect, the Board may revoke probation and carry out the disciplinary order that was stayed after giving respondent notice and the opportunity to be heard. Respondent violated the terms of his probation by failing to obey all laws as set forth above. Therefore, cause exists to revoke respondent's probation and carry out the disciplinary order that was stayed, i.e., revocation of respondent's license.

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PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Physician and Surgeon's Certificate Number C39176, heretofore issued to respondent Robert Norfleet Edwards, M.D.; and/or,

2. Revoking, suspending or denying approval of the respondent's authority to supervise physician assistants; and/or,

3. Ordering respondent to pay the Board the costs of probation monitoring; and/or,

4. Taking such other and further action as the Board deems necessary and proper.

DATED: May 27, 2008.

BARBARA JOHNSTON
Executive Director
Medical Board of California

Complainant

EXHIBIT A

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	Case No. 16-1999-103134
ROBERT NORFLEET EDWARDS, M.D.	)	OAH No. N-2004090444
Respondent/Petitioner.	)	

DECISION AFTER REMAND FROM SUPERIOR COURT

The administrative law judge's proposed decision submitted on February 17, 2005 was adopted by the board on March 10, 2005 to become effective on April 11, 2005.

Thereafter, respondent filed a Petition for Writ of Mandate in Sacramento County Superior court, Case No. 05CS00665, which was heard and granted by the court. On July 26, 2006, the court issued its decision in the matter. The Superior Court of the State of California, commanded this board to vacate and set aside its decision in the above matter dated April 11, 2005 and to reconsider the penalty imposed in light of the court's statement of decision.

Having reconsidered the matter in light of the court's Statement of Decision, the board now vacates and sets aside its decision dated April 11, 2005, and makes the following Decision on Remand in compliance with the Peremptory Writ. A copy of the Peremptory Writ and Statement of Decision is attached as Exhibit "A".

The attached proposed decision (Exhibit "B") of the administrative law judge is adopted by the board as its decision in the matter with the following changes:

1. Factual Finding No. 8 (page 3) is modified to read as follows:

   The Sacramento County Superior Court has found that it would not be against the public interest to allow respondent to retain his license in California

2. Legal Conclusion No. 3 (page 3) is stricken.

3. The Order is modified to read as follows:

Physician's and Surgeon's certificate No. C30405 issued to Robert Norfleet Edwards, M.D. is hereby revoked; provided , however, that revocation is stayed and respondent placed on probation for five (5) years upon the following terms and conditions:

1. Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Division or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Division or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

Respondent shall not practice medicine until respondent has successfully completed the Program and has been so notified by the Division or its designee in writing, except that respondent may practice in a clinical training

program approved by the Division or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

2. Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Division or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Division or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Division, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Division or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all

times during business hours and shall retain the records for the entire term of probation.

The monitor(s) shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine and whether respondent is practicing medicine safely.

It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Division or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Division or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Division or designee.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

4. Prior to engaging in the practice of medicine the respondent shall provide a true copy of the Decision(s) and Accusation(s) to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

5. During probation, respondent is prohibited from supervising physician assistants.

6. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

7. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

8. Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b). Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

9. Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Division or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

10. In the event respondent should leave the State of California to reside or to practice respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following

terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

11. In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

12. Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon completion successful of probation, respondent's certificate shall be fully restored.

13. Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

14. Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

15. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

This decision shall become effective at 5:00 p.m. on December 31, 2006.

IT IS SO ORDERED this 1st day of December, 2006.

CESAR A. ARISTEIGUIETA, M.D.
Chairperson, Consolidated Panel
Division of Medical Quality
Medical Board of California

EXHIBIT A

Peremptory Writ of Mandamus and Statement of Decision

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Attorneys for Respondent

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SACRAMENTO

ROBERT NORFLEET EDWARDS, M.D. Petitioner, v. **MEDICAL BOARD OF CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS; DAVID T. THORNTON; AND DOES 1 THROUGH 10, INCLUSIVE,** Respondents.	**Case No. 05CS00665** **PEREMPTORY WRIT OF MANDAMUS** **[Code of Civil Procedure § 1094.5]**

The People of the State of California

To: Medical Board of California, Respondent

WHEREAS, a Judgment and Order having been entered in this action requiring that a peremptory writ of mandamus be issued from this Court on the Medical Board of California remanding this matter for reconsideration of the penalty to be imposed by the Medical Board of California in the case entitled *In the Matter of the Accusation Against Robert Norfleet Edwards, M.D.*, Case No. 16-1999-103134.

YOU ARE HEREBY COMMANDED immediately on receipt of this writ to set aside

your decision dated April 11, 2005, in the administrative proceedings entitled *In the Matter of the Accusation Against Robert Norfleet Edwards, M.D.*, Case No. 16-1999-103134, which proceedings are hereby remanded to you, to reconsider the penalty imposed in this action in light of this Court's ruling of June 2, 2006, and Order thereon, and to thereafter issue a new Decision. Nothing in this writ shall limit or control the discretion legally vested in you.

YOUR ARE FURTHER COMMANDED to make and file a return to this writ within 15 days of the issuance of a Final Decision rendered by you in accordance with the terms of this Court's ruling and Order thereon.

DATED: 7/26/06

Dennis Jones
Clerk

By: B. Deadrick
Deputy Clerk

In the Superior Court of the State of California

In and for the County of Sacramento

ENDORSED

JUL 2 6 2006

By B. Beddow, Deputy

ROBERT NORFLEET EDWARDS, M.D.

Petitioner,

VS.

Case No.: 05CS00665

MEDICAL BOARD OF CALIFORNIA,

DEPT OF CONSUMER AFFAIRS,

And DAVID T. THORNTON,

Respondents.

STATEMENT OF DECISION

This matter came on regularly for hearing before the Department 19 of the above, entitled Court on June 2, 2006, Judge Patrick Marlette presiding. Stephen L. Ramazzini appeared as counsel on behalf of petitioner Robert Norfleet Edwards, M.D. Deputy Attorney General Susan K. Meadows appeared as counsel on behalf of respondent Medical Board of California.

The record of the administrative proceedings having been received into evidence and reviewed by the Court, and the Court having read and considered the written briefs submitted by the parties and heard oral argument on this matter, the Court makes the following statement of decision:

This is a petition for writ of mandate under Code of Civil Procedure section 1094.5 in which petitioner challenges a decision of respondent Medical Board of California revoking his physician and surgeon's certificate after an evidentiary hearing. The sole basis for the Board's disciplinary order was that the Oregon Board of Medical Examiners had issued an order revoking petitioner's Oregon medical license, staying the revocation, and placing petitioner on probation for five years. The Oregon Board's order was based on its finding that petitioner had "...engaged in unprofessional and dishonorable conduct that is detrimental to the best interests of the public and might constitute a danger to the health or safety of a patient of the public", and, in particular, that petitioner's practice of medicine in the areas of cytology and the performance of autopsies "...included repeated acts of negligence". (See, Verified Petition, Exhibit C, page 7, lines 25-27.)

Because this matter concerns petitioner's vested right to his professional license, the Court has exercised its independent judgment on issues of fact and law. (See, *Griffiths v. Superior Court* (2002) 96 Cal. App. 4th 757.)

Respondent Medical Board's disciplinary order was authorized by Business and Professions Code section 2305, which provides that the "revocation, suspension, or other discipline, restriction or limitation imposed by another state upon a license or certificate to practice medicine in that state...that would have been grounds for discipline in California of a licensee under this chapter, shall constitute grounds for disciplinary action for unprofessional conduct against the licensee in this state." Repeated negligent acts are a proper ground for disciplinary action against a medical license in California. (Business and Professions Code section 2234(c).) Respondent Medical Board's order therefore was within its jurisdiction.

Notwithstanding the clear statutory authority for the Medical Board to act in this case, petitioner contends that its order was improper and deprived him of due process of law. The basis of petitioner's argument is the fact that the Oregon Board's findings against him were made under a lower standard of proof, namely the preponderance of the evidence, than he would have been entitled to had the same charges been brought against him in California, which applies the clear and convincing standard to medical license matters.

The Court finds petitioner's contention to be unpersuasive. Petitioner has not been disciplined in California on charges and findings of repeated negligent acts in the practice of cytology and autopsies, but solely on the charge and finding that he was subject to out-of-state discipline. The fact of such discipline was found by clear and convincing evidence in this case, as the Administrative Law Judge specifically stated.

(See, Verified Petition, Exhibit B, paragraph 4.) Discussion in respondent Medical Board's decision of the conduct underlying the Oregon Board's order was in relation to the statutory mandate that the underlying acts must be grounds for discipline in this state. That statutory mandate is not a directive that the California Board must retry out-of-state charges if sister state agencies apply a different standard of proof to their proceedings; it is a recognition of the important principle that this state may not revoke a professional license unless the licensee's conduct relates to the fitness or competence to practice the profession. (See, *Marek v. Board of Podiatric Medicine* (1993) 16 Cal. App. 4th 1089, 1096.) There is no dispute that the commission of repeated acts of negligence in the practice of cytology and autopsies has the requisite logical nexus or rational relationship to fitness or competence to practice. Respondent's disciplinary order therefore did not violate the applicable statutory authority, Business and Professions Code section 2305.

In effect, petitioner argues that the statute is unconstitutional, at least insofar as it applies to him, by authorizing discipline based on out-of-state disciplinary orders entered under a lesser standard of proof than clear and convincing evidence. Petitioner has not cited any appellate authority so holding. Cases involving the application of collateral estoppel are not apposite because, as discussed above, the instant discipline in California is not based on the acts themselves but on the fact of out-of-state discipline. Moreover, petitioner's view contradicts the compelling policy considerations that militate against any broad inquiry into the licensee's underlying conduct where out-of-state discipline has been imposed, as discussed in *Marek v. Board of Podiatric Medicine* (1993) 16 Cal. App. 4th 1089, 1097-1098. Finally, petitioner has not demonstrated that he was deprived of his

due process rights under Oregon law in the proceedings before the Oregon Board or that those proceedings were otherwise so deficient from a constitutional due process standpoint that the Oregon order should be entitled to no status in California proceedings.

The Court therefore finds that petitioner has not demonstrated that respondent's order was invalid on the basis that proceedings before the Oregon Board utilized a different standard of proof.

Petitioner also argues that respondent Medical Board improperly applied Business and Professions Code section 141 as the basis of its order. This contention is unpersuasive as well. Section 141(a) permits the Medical Board, as one of the agencies under the jurisdiction of the Department of Consumer Affairs, to impose discipline based upon disciplinary action taken by another state "...for any act substantially related to the practice regulated by the California license...." In substance, this provision is identical to Business and Professions Code section 2305, except that it is permissive and the section 2305 is mandatory. It has been held that section 2305 did not impliedly repeal section 141, which may apply where section 2305 does not. (See, *Medical Board v. Superior Court* (2001) 88 Cal. App. 4th 1001, 1004.) Even though discipline in this case properly fell within the scope of section 2305, respondent Medical Board did not err, or at most committed a harmless error, by also citing section 141 as authority for its decision in this case.

Petitioner further argues that respondent Medical Board violated his right to a fair hearing by referring to his conduct in the decision, when only the fact of out-of-state discipline was charged and could properly support discipline under section 2305. This contention, too, is unpersuasive. As noted above, references to petitioner's conduct in respondent's order related to the statutory and constitutional mandate that the grounds for discipline in Oregon be related to petitioner's fitness or competence to practice medicine. Also, the fact that the Oregon Board utilizes a different standard of proof as to the underlying facts did not deprive petitioner of a fair hearing before the California Medical Board. The issue in the California Board's proceedings was limited to whether out-of-state discipline on proper grounds had occurred. Petitioner was provided with a full evidentiary hearing on that question, in which respondent Medical Board applied the clear and convincing evidence standard of proof as required by law. The Court therefore finds that petitioner has not demonstrated that he was deprived of his right to a fair hearing.

Even if, as the Court has found above, respondent Medical Board was entitled to impose discipline on petitioner's California medical license based on the Oregon Board's order, petitioner challenges the level of discipline respondent imposed here. Instead of the stayed revocation with probation that the Oregon Board ordered, respondent ordered the outright revocation of petitioner's license. Petitioner challenges this order on both factual and legal grounds, asserting that it is not supported by the weight of the evidence and that the disciplinary order amounts to a manifest abuse of discretion under the circumstances.

Respondent Medical Board rested its order of outright revocation upon the fact that petitioner has not satisfactorily completed his probation in Oregon and upon certain factual findings regarding petitioner's attitude towards the Oregon Board's order. Specifically, respondent found that petitioner "...has not taken responsibility for the problems with his practice in Oregon. Although he claims to have accepted the Oregon Board's decision, he did not demonstrate any insight into how these problems occurred. Without an understanding of what went wrong, it is impossible to have any confidence that these or similar lapses with [sic] not occur in the future. [...] Until...he can show that he truly accepts and understands the problems with his practice in Oregon, it would not be in the public interest to allow [him] to retain his license in California." (Verified Petition, Exhibit B, paragraphs 6 and 8.)

The Court has reviewed the record of petitioner's testimony at the hearing before respondent Medical Board, upon which these findings were based, and has exercised its independent judgment thereon. Based upon that review, the Court finds that the factual findings supporting the order of outright revocation are not supported by the weight of the evidence. The evidence demonstrates that, although petitioner has not completed all of his probationary obligations in Oregon, he is not out of compliance with any of the Oregon Board's orders, has taken significant steps towards complete compliance, and appears to be making a good faith effort to comply. With regard to petitioner's attitude, the Court finds that petitioner's testimony does not demonstrate the kind of recalcitrance or lack of understanding that respondent found. In the Court's view, petitioner appeared

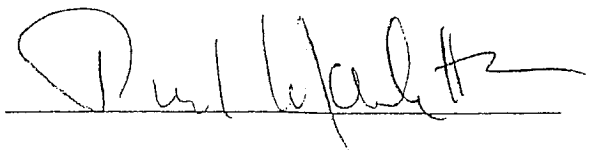
to be no more defensive than any medical doctor might be in accepting responsibility for the specific deficiencies the Oregon Board found while still defending his basic aptitude. Nothing in petitioner's testimony contradicted the observation of the Oregon hearing officer that, although the deficiencies in petitioner's practice were serious, "...none of his actions appeared willful and there was no showing that he is not trainable." (Verified Petition, Exhibit C, page 11, lines 13-14.)

The Court accordingly finds that the weight of the evidence does not support the factual findings respondent Medical Board made in support of its decision to impose a higher level of discipline than that imposed by the Oregon Board.

The final question presented by the petition is whether respondent's order of outright revocation was improper in the absence of those, or similar, factual findings. Generally, the level of discipline imposed by an administrative agency will not be disturbed unless it amounts to a manifest abuse of discretion. (See, *Cadilla v. Board of Medical Examiners* (1972) 26 Cal. App. 3d 961, 967.) In this case, the Court finds that it was a manifest abuse of discretion to revoke petitioner's license outright. As noted above, the Oregon Board, in essence, found that petitioner could remedy his deficiencies with appropriate training and monitoring, and accordingly ordered probation. Respondent Medical Board was not necessarily precluded from concluding otherwise, but should have demonstrated a reasonable and factually-supported basis for doing so. No such basis was demonstrated. Respondent's order of outright revocation therefore cannot be upheld. The petition for writ of mandate therefore is granted solely to the extent of

overturning respondent's order of outright revocation, and the matter is ordered remanded to respondent for reconsideration of the penalty to be imposed. (See, *Magit v. Board of Medical Examiners* (1961) 57 Cal. 2d 74, 88.)

Dated this 17th day of July, 2006



Patrick Marlette, Judge of the Superior Court

EXHIBIT B

Administrative Law Judge's Proposed Decision

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
ROBERT NORFLEET EDWARDS, M.D. Certificate No. C-39176	No: 16-1999-103134
Respondent	

DECISION

The attached Proposed Decision is hereby adopted by the Division of Medical Quality as its Decision in the above-entitled matter.

This Decision shall become effective at 5:00 p.m. on April 11, 2005.

IT IS SO ORDERED March 10, 2005.

By: _____
LORIE G. RICE
Chair - Panel A
Division of Medical Quality

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: ROBERT NORFLEET EDWARDS, M.D., Linkville Medical Laboratories 4509 South 6th Street, Suite 311 Klamath Falls, OR 97603 Physician and Surgeon's Certificate No. C39176 Respondent.	Case No. 16-1999-103134 OAH No. N 2004090444

PROPOSED DECISION

Administrative Law Judge Ruth S. Astle, State of California, Office of Administrative Hearings, heard this matter in Oakland, California on February 3, 2005.

Jane Zack Simon, Deputy Attorney General, represented complainant.

Respondent was present and represented by James P. Martin, Hoffman, Hart & Wagner, Attorneys at Law, 1000 S.W. Broadway, Twentieth Floor, Portland, OR 97205.

The matter was submitted on February 3, 2005.

FACTUAL FINDINGS

1. David T. Thornton made this accusation in his official capacity as Interim Executive Director of the Medical Board of California (Board) and not otherwise.

2. On April 15, 1980, Physician and Surgeon's Certificate No. C39176 was issued by the Board to Robert Norfleet Edwards, M.D. (respondent). Respondent's certificate is renewed and current with an expiration date of January 31, 2006.

3. On August 7, 2003, the Board of Medical Examiners of the State of Oregon (Oregon Board) issued a Final Order regarding respondent's license to practice medicine in Oregon. The Final Order, which followed a hearing on the merits, made findings that

respondent, a pathologist, had demonstrated numerous departures from the standard of practice in several areas of his practice. In particular, the Oregon Board found that respondent committed numerous departures from the standard of practice in his cytology practice, and in so doing, he placed his patients' health and safety at risk. The Oregon Board also determined that respondent's autopsy practice departed from the standard of practice in numerous ways, and evidenced repeated acts of negligence. The Oregon Board concluded that respondent's "poor judgment, lack of attention to detail and lack of follow through" were "indicators of lazy practice habits and a propensity to take short cuts which placed patients at risk of harm and compromised the accuracy of his reports and findings." Based on these findings, respondent's Oregon license was revoked, with the revocation stayed, and he was placed on five years probation. Terms and Conditions of probation include requirements that respondent take substantial continuing medical education courses, over-reading of cytology slides, and review of autopsy reports. The Final Order is attached to the accusation as Exhibit A.

4. The action taken by the Oregon Board does constitute disciplinary action within the meaning of California law. The fact that the standard of proof in the Oregon decision was a preponderance of the evidence as opposed to clear and convincing evidence[1] does not change the fact that it was established by clear and convincing evidence that respondent's medical license was disciplined in another state. Respondent's conduct and the action of the Oregon Board as set forth in Finding 3, above, constitute unprofessional conduct pursuant to Business and Professions Code sections 2305 and 141, subdivision (a).

5. Respondent testified that he is in compliance with his probation in Oregon, but presented no corroboration of this contention. He testified that he has paid the fine in full, completed the additional educational requirements in Pathology and completed half of the required additional educational requirements in cytology, but did not present any corroboration of completion of any additional educational hours.

6. Respondent presented excerpts of testimony from his hearing in Oregon. Two of the excerpts were as character references. The rest was an attempt to retry the decision of the Oregon Board. This demonstrates that respondent has not taken responsibility for the problems with his practice in Oregon. Although he claims to have accepted the Oregon Board's decision, he did not demonstrate any insight into how these problems occurred. Without an understanding of what went wrong, it is impossible to have any confidence that these or similar lapses with not occur in the future.

7. Respondent is the District Medical Examiner for his area in Oregon. He no longer does complex cases. He owns and operates a laboratory with his wife. He is not presently practicing cytology or histology at this time, but plans to resume his practice in these areas in the future. Respondent has a practice in nuclear medicine at Merle West Hospital in Oregon.

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[1] This is the standard of proof required to take disciplinary action against a physician's license in California.

8. Respondent has no present intention to practice medicine in California. Until he has demonstrated that he has satisfactorily completed his probation in Oregon and can show that he truly accepts and understands the problems with his practice in Oregon, it would not be in the public interest to allow respondent to retain his license in California.

9. Costs in the amount of $1,965 are reasonable and respondent is responsible for this amount.

LEGAL CONCLUSIONS

1. By reason of the matters set forth in Findings 3and 4, cause for disciplinary action exists pursuant to Business and Professions Code sections 141 (out of state discipline) and 2305 (unprofessional conduct for out of state discipline).

2 The matters in set forth in Findings 5, 6, 7 and 8 have been considered in making the following order.

3. Cost recovery in the amount of $1,965 is ordered pursuant to Business and Professions Code section 125.3. .

ORDER

1. The Physician and Surgeon's Certificate No. C30405 issued to Robert Norfleet Edwards, M.D is hereby revoked.

2. Respondent shall pay to the Board cost recovery in the amount of $1,965.

DATED: 2/17/05

Ruth S. Astle

RUTH S. ASTLE
Administrative Law Judge
Office of Administrative Hearings

BILL LOCKYER, Attorney General
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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ROBERT NORFLEET EDWARDS, M.D.,** Linkville Medical Laboratories 4509 South 6th Street, Suite 311 Klamath Falls, OR 97603 Physician and Surgeon's Certificate No. C39176 Respondent.	**Case No. 16-1999-103134** **ACCUSATION**

The Complainant alleges:

PARTIES

1. Complainant David T. Thornton is the Interim Executive Director of the Medical Board of California (hereinafter the "Board") and brings this accusation solely in his official capacity.

2. On or about April 15, 1980, Physician and Surgeon's Certificate No. C39176 was issued by the Board to Robert Norfleet Edwards, M.D. (hereinafter "respondent"). Respondent's certificate is renewed and current with an expiration date of January 31, 2006.

JURISDICTION

3. This accusation is brought before the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs (hereinafter the "Division"), under the authority of the following sections of the California Business and Professions Code (hereinafter "Code") and/or other relevant statutory enactment:

A. Section 2227 of the Code provides in part that the Board may revoke, suspend for a period of not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act, and may recover the costs of probation monitoring if probation is imposed.

B. Section 125.3 of the Code provides, in part, that the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the Board a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

C. Section 2305 of the Code provides, in part, that the revocation, suspension, or other discipline, restriction or limitation imposed by another state upon a license to practice medicine issued by that state, that would have been grounds for discipline in California under the Medical Practice Act, constitutes grounds for discipline for unprofessional conduct.

D. Section 141 of the Code

"(a) For any licensee holding a license issued by a board under the jurisdiction of a department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or by another country shall be conclusive evidence of the events related therein.

"(b) Nothing in this section shall preclude a board from applying a

specific statutory provision in the licensing act administered by the board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country."

E. Welfare and Institutions Code section 14124.12 provides, in part, that a physician whose license has been placed on probation by the Medical Board shall not be reimbursed by Medi-Cal for "the type of surgical service or invasive procedure that gave rise to the probation."

4. Respondent is subject to discipline within the meaning of section 141 and is guilty of unprofessional conduct within the meaning of section 2305 as more particularly set forth herein below.

FIRST CAUSE FOR DISCIPLINE

(Discipline, Restriction, or Limitation Imposed by Another State)

5. On or about August 7, 2003 the Board of Medical Examiners of the State of Oregon issued a Final Order regarding respondent's license to practice medicine in Oregon. The Final Order, which followed a hearing, made findings that respondent, a pathologist, had demonstrated numerous departures from the standard of practice in several areas of his practice. In particular, the Oregon Board found that respondent committed numerous departures from the standard of practice in his cytology practice, and in so doing, he placed his patients' health and safety at risk. The Oregon Board also determined that respondent's autopsy practice departed from the standard of practice in numerous ways, and evidenced repeated acts of negligence. The Oregon Board concluded that respondent's "poor judgment, lack of attention to detail and lack of follow through" were "indicators of lazy practice habits and a propensity to take shortcuts which placed patients at risk of harm and compromised the accuracy of his reports and findings." Based on these findings, respondent's Oregon license was revoked, with the revocation stayed, and he was placed on five years probation. Terms and conditions of the probation include requirements that respondent take substantial continuing medical education courses, over-reading of cytology slides, and review of autopsy reports.

Attached as Exhibit A and incorporated by reference is a true and correct copy of the Final Order Board of Medical Examiners, State of Oregon.

6. The discipline imposed by the Board of Medical Examiners, State of Oregon constitutes a violation of section 141 and constitutes unprofessional conduct and/or a basis for the imposition of discipline within the meaning of Code section 2305.

PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division issue a decision:

1. Revoking or suspending Physician and Surgeon's Certificate Number C39176, heretofore issued to respondent Robert Norfleet Edwards, M.D.;

2. Revoking, suspending or denying approval of the respondent's authority to supervise physician assistants;

3. Ordering respondent to pay the Division the actual and reasonable costs of the investigation and enforcement of this case and to pay the costs of probation monitoring upon order of the Division; and

4. Taking such other and further action as the Division deems necessary and proper.

DATED: June 28, 2004.

D. T. Thornton

DAVID T. THORNTON
Interim Executive Director
Medical Board of California

Complainant

Exhibit A

BEFORE THE

BOARD OF MEDICAL EXAMINERS

STATE OF OREGON

In the Matter of ROBERT NORFLEET EDWARDS, JR., MD License No. MD14941	)	FINAL ORDER

HISTORY OF THE CASE

On February 16, 2001 the Board of Medical Examiners (Board) issued a Complaint and Notice of Proposed Disciplinary Action against licensee Robert Norfleet Edwards, Jr., M.D. On February 19, 2001, Dr. Edwards requested a hearing. On May 21, 2002, the Board issued an Amended Complaint and Notice of Proposed Disciplinary Action.

A hearing was held on January 21-24, 2003 in Portland, Oregon. Monica Smith, Hearing Officer, presided.[1] The Board was represented by Assistant Attorney General (AAG) Warren Foote. Dr. Edwards was represented by James P. Martin, attorney-at-law. At the time of hearing, the Amended Complaint (Exhibit 2A) was further amended to delete the reference to ORS 677.188 (4)(c) in paragraph 2 on page one of the complaint and to delete paragraph 3.3 on page two and paragraph 3.10 on page four of the complaint.

Testifying (in order of appearances) on behalf of the Board were Robert N. Edwards, Jr. M.D., licensee, John D. Howard, M.D., Chief Medical Examiner in Pierce County Washington, Roy J. Apter, M.D., Benton County Medical Examiner, William H. Rodgers, M.D., Associate Professor of Pathology and Obstetrics and Gynecology at Oregon Health and Science University (OHSU), Vice Chair for Anatomic Pathology and Medical Director of Anatomic Pathology Laboratories (OHSU Hospitals), Robert A. Fouty, M.D., Founder and Director of Medical Laboratory Associates.

Testifying on behalf of Dr. Edwards were Tim Lancaster, a funeral home director, Edwin Caleb, Klamath County District Attorney, John David Dougherty, detective with Klamath County Sheriff's Office, Joel MacGregor Shilling, M.D., Medical Director of Quest Diagnostics, William Hosack, M.D., Coos County Medical Examiner, and Dr. Edwards.

In rebuttal, the Board recalled Dr. Apter and Dr. Fouty. The last witness to testify for the Board was Karen Gunson, M.D., state medical examiner for Oregon.

On February 18, 2003, the Hearing Officer Panel received a written transcript of the proceeding. The record closed on that date.

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[1] HB 2526 has subsequently renamed the Hearing Officer Panel to be the Office of Administrative Hearings and has changed the title of Hearing Officer to Administrative Law Judge.

ISSUE

Whether Dr. Edwards engaged in any conduct detrimental to the best interests of the public or practice which might constitute a danger to the health or safety of a patient or the public and whether his practice of medicine included gross or repeated acts of negligence. If so, what is the appropriate discipline? ORS 677.188 (4)(a) and ORS 677.190(14).

EVIDENTIARY RULINGS

The Board offered exhibits 1-31. Exhibits 1-6, 11-15, 21, 24-26, and 29-31 were admitted without objection. Dr. Edwards objected to Exhibit 7, 8-10, 16–20, 22, 23, 27, and 28. Dr. Edwards objected to the admission of exhibit 7, a letter from Dr. Donald C. Houghton, on the grounds that the evidence was hearsay and cumulative. There would also be no opportunity to cross-examine the writer Dr. Houghton. The letter is relevant to the charge that Dr. Edwards did not meet the standard of care. It also meets the reliability standards in ORS 183.450(2). The objection was overruled. Dr. Edwards objected to Exhibit 8 on grounds that it was not relevant. Exhibit 8 is a letter written by Mr. Foote to the attorney for Dr. Edwards with documents requested by his attorney. Exhibit 8 is found to be relevant and admitted into the record.

Dr. Edwards objected to Dr. Fouty's reports, Exhibits 9 and 10 on grounds that they were cumulative. His objections were overruled. Dr. Edwards objected to exhibits 16-20 on the grounds that the evidence was hearsay and there would be no opportunity to cross-examine the writers and affiants. Exhibits 16-20 meet the reliability standards in ORS 183.450(2). His objections were overruled. Dr. Edwards objected to exhibits 22 and 23, Practice Guidelines for Forensic and Autopsy Pathology and to exhibit 27 Cervical Cytology Practice Guidelines on the grounds that he could not cross-examine the writers. Exhibits 22-23 and 27 are relevant to the charge that Dr. Edwards did not meet the standard of care. His objections were overruled. Dr. Edwards objected to Exhibit 28, a copy of three pages from the Code of Federal Regulations (CFR). His objection was overruled.

Dr. Edward's exhibits, 101-118, 120-121 and 130 were admitted without objection. Exhibit 129 was previously admitted as Exhibit 114 so it is not included in the record.

FINDINGS OF FACT

(1) The Board of Medical Examiners (BME) is the state agency responsible for licensing, regulating and disciplining physicians in the State of Oregon. Dr. Edwards holds license number MD14941 from the BME. (Ex. 2.)

(2) Dr. Edwards is board certified in anatomic pathology. Dr. Edwards went to the University of Iowa Medical School from 1974 to 1978. He completed a five year residency program at the UC Davis Medical Center in pathology and a three year residency training in nuclear medicine. He completed a one year fellowship at Sioux Valley Hospital in South Dakota. From 1986 - 1992, he was the Director of Nuclear Medicine and Pathology at Merle West Medical Center in Klamath Falls, Oregon. Since 1986, he has been either the Assistant or Deputy Medical Examiner in Klamath County, Oregon. He performs on average 30 autopsies a year in his capacity as Medical Examiner in Klamath County. (Ex. 113.)

Cytology Practice

(3) In 1992, Dr. Edwards and his wife founded Linkville Medical Laboratories. Dr. Edwards has been Medical Director of his lab since 1993. His lab performs screenings of pap smears and other specimens for approximately ten local physicians. Since August 13, 1999, pursuant to a stipulated order with the BME, Dr. Edwards has not read, reviewed or otherwise performed medical services related to the practice of cytological pathology. Dr Jamison is now the Director of Cytology at Linkville Lab. Currently, Dr. Edwards spends the majority of his time performing management functions at his lab. (Ex. 4 and 5.)

(4) The BME directed an independent review of 100 consecutive Pap smears by OHSU. The review covered slides interpreted and read by Dr. Edwards in his lab from January 5, 1998 through February 2, 1998. OHSU found 97 slides suitable for review and disagreed with Dr. Edwards' findings in six cases. Out of the 97 slides, Dr. Edwards read only two slides as atypical squamous cell of unknown significance (ACSUS) or abnormal. OHSU read these same two slides as within normal limits. There were three slides that Dr. Edwards read as normal that OHSU found to have significant abnormal cells. OHSU read one of these slides as high grade squamous intraepithelial lesion (HSIL) which Dr. Edwards read as normal. The final disagreement was on a slide with a high grade abnormality that had been read by Dr. Edwards as "unsatisfactory sample due to excessive blood," but OHSU found it to be a "satisfactory sample limited by blood atypical cells suspicious for adenocarcinoma." (Ex. 8.)

(5) Dr. Rodgers was one of the OHSU reviewers of the 100 slides and certified as an expert. He opined that it would not be unusual to find two to four low grade types of cases in such a review but to find two high grade abnormalities that Dr. Edwards missed suggests a significant breach of the standard of practice for a lab. He further opined that there are very clear standards for reporting abnormal cells and to not report it by saying it was unsatisfactory as Dr. Edwards did in this matter was not only "shocking" to him but a clear-cut violation of the standard of care for a cytologist. Based on his personal review of these slides, Dr. Rodgers opined that there was a potential for patient harm by Dr. Edwards in his manner of practice toward those slides that he reported as unsatisfactory. (1/22/03 transcript at 13-32.)

(6) Dr. Edwards testified that in the case that he reported as unsatisfactory, he had called the physician and told him of the potential for cancer even though this was not written down anywhere. There was no actual patient harm because at the time of the Pap test, a vaginal mass was discovered and the patient got timely treatment. (Ex. 102.)

(7) A larger sample of slides was obtained from Linkville Medical Labs for the time period of February 1999 through August 1999 for review by Dr. Fouty. Dr. Fouty was certified[2] as an expert in cytology. Dr. Fouty reviewed 598 slides and concluded that large numbers of slides were understained. Eighty cases were so severely understained that endocervical cells could not be interpreted thereby negating the validity of the interpretation of the Pap smear. Dr. Fouty suggested that all eighty cases be re-stained and re-screened. Ninety-four cases of the slides were classified as less than optimal for staining. These also needed to be restained and rescreened. Thirty of the slides reviewed were identified as atypical. Dr. Fouty recommended

[2] The hearing officer used the term "certified" when referring to witnesses that she found to be qualified as expert witnesses in the case. We adopt her proposed findings in this regard while interpreting her use of the term "certified" to mean qualified as an expert witness. We will use the term "qualified" henceforth in this Final Order.

that these 30 atypical slides be reported back to the patients and that repeat analysis be done. (Ex. 9.)

(8) Dr. Edwards explained that at the time that he reviewed the understained slides, he thought he could compensate for the lack of staining by spending more time on each slide and increasing the power on his microscope and turning down the condenser. Dr. Rodgers opined that this method of compensating is not a standard of practice in cytopathology. Microscopic technique cannot compensate for improperly stained slides. It is not a method that is capable of accurately identifying abnormal cells. Dr. Edwards' responsibility as a pathologist and director of the lab was to recognize the inadequate staining and restain the slide before interpreting it. (1/22/03 transcript at 29-32.)

(9) There are three stains in a Pap stain. There are stains for the cytoplasm and stains for the nucleus. They do not all penetrate at the same rate. When a slide is understained, the small malignant cells are not going to be visible. Even when the slides are stained properly, small malignant cells can be missed. Increasing the power on your microscope and spending more time reading each slide cannot make up for inadequate stain. (Ex. 28 and 1/22/03 transcript at 84-108.)

(10) Dr. Fouty opined that the decision Dr. Edwards made to go ahead and screen an understained slide placed each patient at risk and was a violation of the standard of practice in cytology. Dr. Fouty has such significant concerns about Dr. Edwards' ability to safely practice cytology that he found it difficult to sleep after personally reviewing the manner of Dr. Edwards' practice in cytology. Each of the eighty slides that Dr. Fouty found too lightly stained to screen was a separate violation of the standard of practice for a cytologist. (1/22/03 transcript at 84-124.)

(11) Dr. Edwards is also required to report when no endocervical cells are present on a slide and not doing so constitutes a breach of the standard of care in Dr. Fouty's opinion. Dr. Schilling opined that a cytologist is required to report when no endocervical cells are present on a slide even though the lack of such cells does not indicate whether or not a precancerous lesion is present. Dr. Shilling also testified that if he had 80 understained slides reported as negative in his lab when they were really unsatisfactory, he would have taken corrective action. (1/22/03 transcript at 84-124 and 1/23/03 transcript at 43-56.)

(12) Dr. Edwards testified that he felt that the value of the pap test is not in the fact that every time you look at something, you make a "right on" diagnosis, but the value is in the repeatability of the test. He went on to say that the real beauty of the pap test is in its sequential nature and that if he made a mistake and missed one of out four consecutive tests, he would still have a sensitivity rate of 98.4%. (1/21/03 transcript at 63-67 and 1/24/03 transcript at 20-21.) Dr. Edwards also testified that he has no way of knowing if a woman is coming in every year or not for pap tests as he only reviews pap smears of certain doctors and the patient may be seeing a doctor for whom he does not do screenings. (1/24/03 transcript at 52-55.)

(13) Dr. Edwards read a biopsy of Patient F's prostate. Dr. Edwards signed a report, which concluded that Patient F had a "benign prostatic hyperplasia-prostate." This was inaccurate. The report should have reflected that Patient F had a grade 5 adenocarcinoma of the prostate. (1/21/03 transcript at 189 and Ex. 21F.)

Autopsy Practice

Patient A

(14) Dr. Edwards conducted a postmortem examination of Patient A, who was killed in a motor vehicle accident. Patient A apparently lost control of his van and crashed head on into another van. Patient A was thrown through the back right rear window of his van and his body was found on the pavement behind his vehicle. A witness at the scene said Patient A was still breathing when she got to him and for 20 minutes after the accident, but that he had stopped breathing by the time the ambulance arrived. Patient A's corpse exhibited external evidence of injuries to the head and chest. Dr. Edwards did not conduct an internal examination of the head and neck. He concluded that the cause of death was myocardial infarction, old and recent. He based his decision on an external examination of the body, a limited internal examination of the heart, and at least in part ruled out head, neck and spinal cord injury based on the absence of evidence that Patient A had bitten his tongue and the lack of postmortem eye abnormalities. (Ex. 21A and 1/21/03 transcript at 125-134.)

(15) A death certificate prepared based on Dr. Edwards' findings indicated that the cause of death was acute myocardial infarction. Dr. Gunson, State Medical Examiner for Oregon, prepared a corrected death certificate for Patient A indicating that the cause of death was chest injuries and myocardial infarction. Dr. Gunson qualified as an expert. She opined that Dr. Edwards breached the standard of care in not performing a full autopsy on Patient A. Because no microscopic tests were done on the heart, the exact time of the recent myocardial infarction could not be pinpointed. A person can have a myocardial infarction and not die from it. (Ex. 3 at 14.) While the cardiac events were temporally related to a head on collision, the cause and effect were not clear. Dr. Edwards' reliance on the lack of tongue biting to rule out the need for an internal head and neck examination was misplaced and falls below the standard of care for interpretations in the opinion of Dr. Gunson. (Ex. 21A, 1/21/03 transcript at 129-134 and 1/24/03 transcript at 91-92.)

(16) Dr. Howard qualified as an expert. He opined that biting or not biting the tongue is not a reliable means of determining whether someone does or does not have a neck injury or some kind of central nervous system injury. Dr. Howard further found that Dr. Edwards' reliance on tongue biting and eye findings for determining injury is an interpretation that falls below the standard of care. (1/21/03 transcript at 130-134.)

(17) Dr. Lewman, State Medical Examiner for Oregon at the time Patient A died, opined in his written review of this case that a thorough intracranial and neck examination is mandatory in the victim of a high speed vehicular crash, since head and neck injuries are common causes of death in vehicular fatalities. (Ex. 19.) Dr. Edwards did not ask for nor have the history of Patient A before performing the autopsy. (Ex. 3 at 20.) Dr. Howard opined that medical history is critical so that anatomic findings can be correlated with the history to determine the sequence of events leading to death. Physical findings alone do not allow for an adequate understanding of the manner of death. (1/21/03 transcript at 150.)

Patient B

(18) Patient B's family asked Dr. Edwards to conduct a second postmortem examination of her body. Dr. Edwards concluded that there was evidence of a neck injury and reported his findings to the brother of the deceased. He made this conclusion without conducting an internal examination of the cervical vertebrae or spinal cord. He based his finding in part on evidence that Patient B had bitten her tongue and had bleeding in the neck area. A subsequent autopsy by the State Medical Examiner established that Patient B died of a ruptured abdominal aortic aneurysm and that there was no neck injury associated with her cause of death. (Exhibit 21B and 1/21/03 transcript at 134-140.)

(19) Dr. Lewman opined that the correct cause of death would have been obvious had Dr. Edwards cross-sectioned the abdominal aorta. (Ex. 19.) Dr. Howard opined that Dr. Edwards breached the standard of care in this case by not doing a complete autopsy. (1/21/03 transcript at 140.)[3] Dr. Edwards admitted that he did not complete the autopsy because it was late at night and he thought he had reached the correct conclusion. (Ex. 3 at 45.) Dr. Edwards felt that the fact that Patient B had bitten her tongue was really critical and proved that there was a neck problem. (Ex. 3 at 35.) Dr. Edwards did not ask for the history of the patient before performing the autopsy. He did not want the facts of the case to bias him beforehand. (Ex. 3 at 37-40.)

Patient D

(20) Patient D was a newborn infant whose death was attributed to asphyxia by smothering. Dr. Edwards performed an autopsy on Patient D and did not remove certain internal organs including the kidneys, liver and spleen nor did he remove the brain. Dr. Gunson opined that Dr. Edwards' examination of Patient D was not thorough in determining the cause of death. Dr. Gunson performed a second autopsy of Patient D. She was surprised to find most of the organs still in place after Dr. Edwards' autopsy. Although she reached the same conclusion that Patient D died of asphyxia by smothering, she opined that Dr. Edwards did not meet the standard of care on this case because his autopsy was incomplete. In a homicide case, it is important to do a complete autopsy. Dr. Gunson testified that "when you have a baby like this, it is extremely difficult at best and thoroughness is of utmost importance." (1/24/03 transcript at 96.)

(21) Dr. Howard also opined that Dr. Edwards did not meet the standard of care in the case of Patient D. By not removing the internal organs, the body cavities and the connective tissues around the organs cannot be examined in the kind of detail that would be the standard of practice for addressing issues that come up in the death of an infant. Not only removal of all the organs including the brain but also histologic sampling is required to meet the standard of practice in this case. Histologic sampling is taking a tissue sample and studying it under a microscope. (1/21/03 transcript at 142 -147.)

Patient E

(22) Patient E was a seven year old child who died in a motor vehicle collision while sitting unrestrained in the front seat. Dr. Edwards examined the body and concluded that the

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[3] Even Dr. Hosack, a witness for Dr. Edwards, could not say that the standard was met in this case. (1/23/03 transcript at 63-66.)

cause of death was deployment of an airbag secondary to a motor vehicle accident that resulted in a fracture of the child's cervical vertebrae with a spinal cord injury. Dr. Edwards did not conduct a complete autopsy by failing to open the skull, remove the brain and visually examine the base of the skull as well as the upper spinal canal and cord. Dr. Edwards alluded to the deceased biting the tongue as evidence of a spinal cord injury. There was a CT scan performed that indicated that Patient E had a broken neck. Dr. Edwards testified that he did not perform a complete examination because the child was of Native American descent and he did not want to upset the family by disturbing the body anymore than was necessary. Due to the public safety issues raised in this case, a complete examination should have been conducted despite the concern for the family's preference. Dr. Howard testified that a District Attorney should not determine the standard of care or medical judgment for a medical examiner. (1/21/03 transcript at 184.)

Patient G

(23) Dr. Edwards performed an autopsy on a 75 year old female at the request of the family. Patient G's health history included a total abdominal hysterectomy. Dr. Edwards wrote in his autopsy report that Patient G had a normal uterus, fallopian tubes and ovaries. Dr. Apter, qualified as an expert, and Dr. Rodgers both found this inaccurate report to be a breach of the standard of care.[4] Dr. Edwards admitted that he did not go back and edit his report properly before signing it. (Ex. 21G at 4 and 1/21/03 transcript at 115.)

CONCLUSION OF LAW

Dr. Edwards has engaged in unprofessional and dishonorable conduct that is detrimental to the best interests of the public and might constitute a danger to the health or safety of a patient or the public. His practice of medicine included repeated acts of negligence.

OPINION

ORS 677.190 sets out the authority of the Board to discipline licensees. The Board relies on sections (1) (a) and (14) for requesting a revocation of Dr. Edwards' license. ORS 677.190 provides in relevant part:

> The Board of Medical Examiners for the State of Oregon may refuse to grant, or may suspend or revoke a license to practice for any of the following reasons:
>
> (1)(a) Unprofessional or dishonorable conduct.
>
> * * * * *
>
> (14) Gross negligence or repeated negligence in the practice of medicine.

ORS 677.188 (4) provides in relevant part:

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[4] Dr. Edwards' witness, Dr. Hosack, agreed that this was a breach, but he did not feel it was a "big deal." (1/23/03 transcript at 71.)

Unprofessional or dishonorable conduct means conduct unbecoming a person licensed to practice medicine or podiatry, or detrimental to the best interests of the public, and includes:

> (a) Any conduct or practice contrary to recognized standards of ethics of the medical or podiatric profession or any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public or any conduct, practice or condition which does or might impair a physician's or podiatric physician and surgeon's ability safely and skillfully to practice medicine or podiatry.

The Board bears the burden of proof by a preponderance of the evidence. ORS 183.450(2), *Gallant v. Board of Medical Examiners*, 159 Or App 175, 183 (1999).

Cytology Practice

42 CFR 493.1257(a)(1) provides that a lab must assure that "all gynecologic smears are stained using a Papanicolaou or modified Papanicolaou staining method." In Dr. Edwards' cytology practice, it was established by a preponderance of evidence that he engaged in repeated acts of negligence, falling below the standard of care on repeated occasions. This was borne out by the testimony of Dr. Fouty, who found 80 of the slides he reviewed to be so severely understained that they could not be screened properly. Each one of these slides was an individual count of negligence and therefore, eighty examples of the same mistake would qualify as repeated acts of negligence. Dr. Fouty also found thirty slides that were atypical and ninety-four slides that were less than optimal. Since Dr. Fouty's review was limited to a discrete slice of time, it is not known how many other patients were put at risk by the understaining problem at Dr. Edwards' lab. None of the experts who testified found that Dr. Edwards' practice of spending more time on each slide and increasing his microscope power could compensate for the severe understaining. The health and safety of these patients were in jeopardy by not having an accurate screen of their slides. Dr. Edwards himself admitted that there was a significant staining problem and that in retrospect he should not have gone ahead and interpreted the poorly stained slides. (Ex. 11.) He gave no reasonable explanation for not having corrected his mistake after viewing the first poorly stained slide. It was his responsibility to the public to make sure the staining was done properly so that an accurate diagnosis could be made.

Even Dr. Shilling, a witness for Dr. Edwards, said that had his lab reported 80 understained slides as negative that were really unsatisfactory, he would have taken corrective action. Dr. Edwards took no action on these slides until the involvement of the Board. His cavalier attitude toward the Pap test was also disturbing. Dr. Edwards testified that it was not so important to make a correct diagnosis on each Pap smear because Pap tests are done each year. He said that he could miss one out of four and still have a high sensitivity rate. Yet he admitted that he does not know if a particular patient is coming in every year or not.

Both Dr. Fouty and Dr. Rodgers opined, and we so find, that Dr. Edwards engaged in conduct in his cytology practice that put patients' health and safety at risk. Dr. Rodgers

reviewed a slide that Dr. Edwards reported as unsatisfactory for screening which had a high grade cancer. Thankfully, this patient had a vaginal mass and was treated for the cancer promptly but the potential for harm was there because of the way in which Dr. Edwards reported this case. His written report reflected her slide was unsatisfactory yet Dr. Edwards said he called her doctor to inform him of the cancer. Calling someone without also writing it down has never met the standard of practice in the medical profession. To report a slide as unsatisfactory that has atypical cells suspicious for cancer was not only "shocking" to Dr. Rodgers but in his opinion a clear cut violation of the standard of care. The Board agrees.

In the case of Patient F, Dr. Edwards signed a report indicating there was no cancer present in the sample when in fact there was a very aggressive form of cancer. This is another example of conduct dangerous to the health of the public. For the reasons stated above, Dr. Edwards was repeatedly negligent and thereby violated ORS 677.190(14). He also engaged in unprofessional and dishonorable conduct by practicing medicine in a manner that constitutes a danger to the safety of the public, thereby violating ORS 677.190 (1) (a). Dr. Fouty recommended that Dr. Edwards receive additional training in cytology before being allowed to practice in that area again. He said that anywhere from six months to one year of additional training would be sufficient. Dr. Fouty also suggested that some follow-up take place after this required education is completed to ensure that the slides are being screened accurately.

Autopsy Practice

In Dr. Edwards' autopsy practice, there was evidence of repeated acts of negligence. The first autopsy case involved Patient A, who was in a motor vehicle accident. Dr. Edwards performed the autopsy on this patient and ruled out the need for an internal head and neck examination, based on the absence of evidence that the patient had bitten his tongue or had eye abnormalities. Biting or not biting the tongue is not a reliable means of determining whether someone has neck or central nervous system injury. (1/21/03 transcript at 130-134.) Relying on tongue biting or eye findings for determining injuries as a method of interpretation falls below the standard of care. A thorough head and neck examination is mandatory in the victims of vehicular crashes since head and neck injuries are common causes of death in vehicular fatalities. Dr. Lewman, former state medical examiner for Oregon, Dr. Gunson, state medical examiner for Oregon, and Dr. Howard all opined and we so find that Dr. Edwards did not meet the standard of care in this case. In certain types of vehicular fatalities, autopsies may not be required, but once undertaken the autopsy should be complete. For instance, in a case such as this, a thorough intracranial and neck examination is necessary for a victim of a high speed vehicular crash because head and neck injuries are common causes of death. (*See* Ex. 19). Dr. Edwards also did not ask for the medical history before performing the limited autopsy on Patient A. We find Dr. Edwards' perspective that reviewing a patient's history would somehow inject "bias" into his thought process to be below the standard of care in Oregon. This attitude and manner of practice cuts him off from a valuable source of information. Dr. Howard opined and we agree that medical history is critical so that anatomic findings can be correlated with the history to determine the sequence of events leading to death.

Dr. Edwards also did not ask for the patient history before performing the autopsy of Patient B. In this case he reported a neck injury without conducting an internal examination of the cervical vertebrae or spinal cord. Dr. Lewman established that Patient B died of a ruptured abdominal aortic aneurysm and that there was no neck injury associated with her cause of death.

(Exhibit 21B and 1/21/03 transcript at 134-140.) Dr. Lewman says that the correct cause of death would have been obvious had Dr. Edwards cross-sectioned the abdominal aorta. (Ex. 19.) Dr. Edwards performed only a limited autopsy on Patient B. Dr. Howard opined that Dr. Edwards breached the standard of care in this case by not doing a complete autopsy. (1/21/03 transcript at 140.) Even Dr. Hosack, a witness for Dr. Edwards, could not say that the standard was met in this case. Dr. Edwards' manner of conducting this autopsy was negligent and did not meet the standard of care. Dr. Edwards felt that that fact that Patient B bit her tongue was really critical. Again, biting or not biting the tongue is not a reliable means of determining whether someone has neck or central nervous system injury. Relying on tongue biting or eye findings for determining injuries is an interpretation that falls below the standard of care.

Patient D was a newborn infant whose death was attributed to asphyxia by smothering. Dr. Edwards performed an autopsy on Patient D and did not remove certain internal organs. Dr. Edwards' examination of Patient D was not thorough. And in a homicide case, the public could be placed at risk by conducting an incomplete examination that could contribute to leaving a killer at large. When Dr. Gunson performed a second autopsy of Patient D, she was surprised to find most of the organs still in place after Dr. Edwards' autopsy. Although she reached the same conclusion that Patient D died of asphyxia by smothering, both she and Dr. Howard opined that Dr. Edwards did not meet the standard of care on this case because his autopsy was incomplete. This was a homicide case, as well as a newborn infant, and as such it was important to have a complete autopsy done. Not doing so breached the standard of care.

Patient E was a young child who was seated in the front seat of a vehicle without a seatbelt when it was struck by another vehicle. He was killed in the collision. Dr. Edwards attributed his broken neck and resulting death to the deployment of the air bag. Again, Dr. Edwards only performed a limited or incomplete autopsy. Although there was a CT scan that indicated the child's neck was broken, Dr. Edwards did not resolve the cause of death, so the breach of the standard of care was of a lesser magnitude than the other cases. Nevertheless, we are concerned that he would attribute the cause of death where serious public safety issues are raised without conducting a complete autopsy.

In the case of Patient G, Dr. Edwards reported that a normal reproductive system was present when the patient had a hysterectomy. Dr. Apter and Dr. Rodgers both opined this inaccurate report to be a breach of the standard of care. Dr. Edwards' witness Dr. Hosack agreed that this was a breach even though he did not feel it was a "big deal." This case represents yet another example where Dr. Edwards was inattentive to detail and signed off on reports that were inaccurate.

In five autopsy cases, the evidence demonstrated by a preponderance of the evidence that Dr. Edwards engaged in practice that fell below the standard of care. A core principle of forensic pathology is to "see for oneself" in order to determine the cause of death. If a physician conducts what under the circumstances is an incomplete autopsy that yields an incorrect or secondary result, then public health and safety officials are deprived of valuable information and public safety is compromised. For example, if the cause of death is not correctly determined, accident investigators could be misguided and safety measures to avoid future harm unnecessarily delayed. In cases of a disease process, other family members suffering from the same disease could experience unnecessary delay in their diagnosis and treatment. Finally, in a homicide case, an incomplete autopsy could deprive law enforcement officials from important

investigative information, thereby putting the public at risk. Mistakes also jeopardize the integrity of death statistics. Dr. Edwards' acts with regard to the five cases discussed were repeated acts of negligence. They also constitute unprofessional or dishonorable conduct in that his actions did or might constitute a danger to the health or safety of the public.

Discipline Discussion and Sanction

Dr. Edwards has violated ORS 677.190 in both his cytology and autopsy practices. ORS 677.205 discusses the methods for disciplining a licensee. The Board's counsel argued at the hearing for a revocation of his license, and Dr. Edwards requested no discipline. The Hearing Officer was of the opinion that the evidence supports some discipline but did not feel that a revocation is necessary at this time. The Hearing Officer suggested that while Dr. Edwards demonstrated poor judgment, lack of attention to detail and lack of follow through, none of his actions appeared willful and there was no showing that he is not trainable. Therefore, she proposed that the license of Dr. Edwards to practice medicine be suspended for ten years, but that the order to suspend be stayed and he be placed on probation for ten years. If deficiencies are found in his practice of medicine after his educational requirements are met, then the suspension could be re-imposed. In addition, the Hearing Officer recommended the following:

(1) Licensee to pay for the costs of the hearing under ORS 677.205
(2) Licensee shall not perform cytology practice until he has completed 50 hours of board approved coursework in cytology. His first 300 Pap smears after training will be reviewed by a Board approved physician and determined to be satisfactory. For a year after that 20% of his Pap smears will be over read and all will be subject to inspection thereafter and determined to be satisfactory.
(3) Licensee will complete 50 hours of Board approved training in forensic pathology.
(4) Licensee will make his medical records available to the Board for inspection upon request.
(5) Licensee is subject to further disciplinary action, up to and including revocation of his medical license, if he violates any of these terms.

ORDER

The Board views Licensee's poor judgment, lack of attention to detail, and lack of follow through as indicators of lazy practice habits and a propensity to take shortcuts which placed patients at risk of harm and compromised the accuracy of his reports and findings. As a result, the Board believes a stronger sanction should be imposed which will underscore the necessity for this physician to put his patients first and to conform his practice to the standard of care. While the Hearing Officer recommended that the Board impose hearing costs, the Board does recognize Licensee's cooperation with its investigation to include limiting his practice and to incur approximately $10,000 in expenses when the Board asked him to have a specified number of slides over-read. For this reason, the Board has chosen not to impose hearing costs in this matter. The Board, however, does impose the following sanctions and terms:

(1) Licensee's Oregon license to practice medicine is revoked, however, this revocation is stayed, and the licensee is placed on probation for a period of five (5) years subject to the following terms:

(2) Licensee is reprimanded.
(3) Licensee is fined $5,000, to be paid in full within 60 days from the signing of this Order.
(4) Licensee shall not practice cytology until he successfully completes 50 hours of Continuing Medical Education in cytology. The course(s) is to be pre-approved by the Board's Medical Director.
(5) Once term (4) above is successfully completed and Licensee returns to the practice of cytology, a pathologist who has been pre-approved by the Board's Medical Director shall over-read Licensee's first 300 Pap smears. Thereafter, 20% of all Licensees' Pap smear reads shall be over-read by the Board approved pathologist.
(6) Licensee shall complete 50 hours of Continuing Medical Education in forensic pathology. The course(s) is to be pre-approved by the Board's Medical Director and must be completed within two years from the date this Order is signed by the Board Chair.
(7) Licensee shall submit all of his forensic autopsy reports to the State Medical Examiner, or a pathologist approved by the Board's Medical Director, for review. This reviewing pathologist shall provide a report on this review to the Board's Medical Director on an annual basis. Licensee may request that this term be lifted after submitting at least 20 forensic autopsy reports for review.
(8) Licensee shall report in person to the Board at each of its regularly scheduled quarterly meetings at the scheduled times for a probationer interview unless ordered to do otherwise by the Board.
(9) Should Licensee be absent from this state for any period of time which would interfere with meeting the requirements of these terms of probation, Licensee must request approval for alternative means of satisfying those terms. Failure to receive Board approval may result in an extension of this probation for a time equivalent to time Licensee has been absent for the State or other action set forth in paragraph.
(10) Any deviation from the terms of this Order by Licensee shall be grounds for discipline pursuant to ORS 677.190.

DATED this 7th day of August, 2003.

BOARD OF MEDICAL EXAMINERS
State of Oregon

JUDITH L. RICE
BOARD CHAIR

Appeal

If you wish to appeal this final order, you must file a petition for review with the Oregon Court of Appeals within 60 days after the final order is served upon you. *See* ORS 183.480 et seq. If this Order was mailed to you, the date of service is the day it was *mailed,* not the day you received it. If you do not file a petition for judicial review within the 60-day time period, you will lose your right to appeal.

EXHIBIT B

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of	)	
	)	
ROBERT NORFLEET EDWARDS, JR., M.D.	)	FINAL ORDER
LICENSE NO. MD14941	)	
	)	

HISTORY OF THE CASE

On July 24, 2006, the Oregon Medical Board (Board) issued an Amended Complaint and Notice of Proposed Disciplinary Action to Robert Norfleet Edwards, Jr., M.D. (Licensee) alleging violations of the Medical Practice Act. Licensee requested a hearing. On August 18, 2006, the Board referred this case to the Office of Administrative Hearings (OAH).

Hearings were held on February 13, February 14, April 24, and April 25, 2007, at the Board's Offices in Portland, Oregon. William A. Halpert, from the OAH, presided as the Administrative Law Judge (ALJ). The Board was represented by Warren Foote, Senior Assistant Attorney General. Licensee appeared at the hearing and was represented by James P. Martin.

Licensee testified at the hearing. Testifying on behalf of the Board were: Michael Propst, M.D., Karen L. Gunson, M.D., Sally Aiken, M.D., Marco Ross, M.D., Gary Gate, M.D. and Vickie Wilson (Board Investigator). Expert witnesses testifying on behalf of Licensee included Matthias Okoye, M.D., David Shelton, M.D., and a declaration by Dennis Wickham, M.D.

The record closed on June 19, 2007,[1] upon receipt of the complete written transcripts of the hearings.[2] The Board received the Proposed Final Order from ALJ Halpert on December 20, 2007.

ISSUES

1. Whether Licensee engaged in unprofessional or dishonorable conduct in his forensic and nuclear medicine practices, ORS 677.190(1)(a), as defined by ORS 677.188(4)(a); as well as whether Licensee engaged in gross or repeated acts of negligence, ORS 677.190(14).

2. If the violations occurred, what is the appropriate sanction?

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[1] The record had to be reopened to receive the complete written transcript of the second day of hearings.

[2] The transcript was prepared in four sections. Transcript 1 (tr. 1) refers to the proceedings on February 13, 2007; transcript 2 (tr. 2) refers the proceedings on February 14, 2007; transcript 3 (tr. 3) refers to the proceedings on April 24, 2007; and transcript 4 (tr. 4) refers to the proceedings on April 25, 2007.

EVIDENTIARY RULINGS

Board Exhibits A1 through A30 and Licensee's Exhibits E1 through E141 were admitted at hearing without objection.

RULING BY THE ALJ ON DR. EDWARD'S MOTION

On April 19, 2007, Licensee filed a Motion to Dismiss the Board's Notice of Proposed Disciplinary Action. To the extent this is a Motion to Dismiss, the ALJ ruled that it was not timely filed. ORS 137-003-0630(1) requires a party to file motions at least seven calendar days before the hearing. The hearing actually commenced two months before Licensee filed the Motion. To the extent the Motion is a Motion for Summary Determination, because Licensee asserts that he is entitled to a favorable ruling as a matter of law, the ALJ opined that he lacked the authority to rule on such Motion. The Board has decided by rule, that the summary determination process is not available to parties to contested case hearings. OAR 847-001-0025. Consequently, the ALJ denied Licensee's Motion.

FINDINGS OF FACT

1. Robert Norfleet Edwards, Jr. (Licensee), is a physician licensed to practice in Oregon. In the past, Licensee was the Klamath County District Medical Examiner. He has also done private autopsies, which are usually at the request of a deceased person's family. At the time of the hearings, he was medical director and co-owner of the Linkville Medical Laboratories. He has done few autopsies in the recent past. (Dr. Edwards; tr. 1 at 17.)

2. On August 7, 2003, the Board issued a Final Order revoking the medical license of Licensee but staying that revocation and placing Licensee on five years probation with conditions, to include taking 50 hours of Board approved training in forensic pathology. In 2003, Licensee was the Klamath County District Medical Examiner and also had a cytology practice. In the 2003 Order, the Board found Licensee repeatedly negligent in his cytology and forensic practices. (Ex. A3.) In this Order, the Board stated the following: "The Board views Licensee's poor judgment, lack of attention to detail, and lack of follow through as indicators of lazy practice habits and a propensity to take shortcuts which placed patients at risk of harm and compromised the accuracy of his reports." (Ex. A3 at 11.)

Forensic Medicine Practice

3. Michael Propst, M.D., is a physician licensed to practice in the State of Oregon. He specializes in forensic medicine. He is familiar with Oregon and national autopsy standards. He served as Alaska's first state medical examiner and practiced in Alaska for 30 years as a medical examiner before returning to Oregon in 2001. He last performed an autopsy in 2001. (Dr. Propst, tr. 1 at 54-57.)

4. The 2003 Order required Licensee to submit 20 autopsy reports to the State Medical Examiners or to a pathologist approved by the Board's Medical Director for

review. At the Board's request, Dr. Propst reviewed the 20 reports prepared by Licensee. (Dr. Propst, tr. 1 at 64-67.) Dr. Propst generally found that Licensee did not meet the standard of care in 19 of the 20 autopsy reports that he reviewed.[3]

5. In the case of Patient A, Licensee found that the cause of death was pneumonia. Dr. Propst believes that Licensee should not have relied solely on a physical examination of the lung tissue and should have microscopically examined lung fluid to confirm pneumonia as the cause of death. Without microscopic studies, Licensee could not have ruled out tuberculosis, a significant threat to public health. (Dr. Propst, tr.1 at 67-72; Ex. A6 at 1-4.)

6. In the case of Patient B, Licensee found that the cause of death was asphyxia resulting from multiple trauma injury at work. In Dr. Propst's opinion, Licensee should have described the specific cause of the injury and failed to make sufficient findings to rule that the cause of death was asphyxiation. Licensee also neglected to weigh, or estimate the weight of, the lungs, which Dr. Propst believes is required to conclude that the cause of death was asphyxiation. (Dr. Propst, tr. 1 at 72-75, Ex. A6 at 5-9.)

7. In the case of Patient C, Licensee found the cause of death was cardiomegaly with congestive heart failure. According to Dr. Propst, cardiomegaly with congestive heart failure are descriptions of the findings and not, in themselves, a proper conclusion for a cause of death. In Dr. Propst's opinion, Licensee should have removed and weighed the heart and lungs and microscopically examined tissue because he made findings of heart and lung disease. The Board also agrees with Dr. Propst that Licensee should have taken a culture after noting pus in the lungs. (Dr. Propst, tr. 1 at 76-78; Ex. A6 at 9-11.)

8. In the case of Patient D, Licensee found the cause of death was myocardial infarction, old and recent. According to Dr. Propst, this is a finding, not a proper conclusion for a cause of death. The Board agrees with Dr. Propst that the cause of death should have been noted to be atherosclerotic coronary artery disease. While Dr. Propst agreed with Licensee that Patient D died from coronary illness, he also testified, and the Board agrees, that Licensee should not have relied upon his gross examination, but should also have done microscopic examinations of the heart to prove the actual disease process. Dr. Propst also believes that Licensee should have microscopically examined the kidneys because he diagnosed chronic renal disease. (Dr. Propst, tr. 1 at 80-81; Ex. A6 at 12-14.)

9. In the case of Patient E, Licensee found that the cause of death was a myocardial infarction. In Dr. Propst's opinion, there is a significant discrepancy between Licensee's estimate of the heart weight and the increased thickness of the walls of the left ventricle described in the autopsy report, which was noted to be 2.7 centimeters thick. Dr. Propst also believes that Licensee should have microscopically

[3] The ALJ stated this as 20 out of 20 autopsy reports. The Board reviewed the record, and found that the ALJ did not specifically address Dr. Propst's testimony in regard the autopsies conducted in regard to Patients O and T.

examined the liver because he found it enlarged but offered no explanation for this. (Dr. Propst; tr. 1 at 81, 83-84; Ex. A6 at 16-17.)

10. In the case of Patient F, Licensee gave several diagnoses, including old and recent myocardial infarction and subdural hematoma. In Dr. Propst's opinion, because Licensee noted a subdural hemotoma, he should have examined the subdural membrane and described the possible cause of the hematoma. (Dr. Propst, tr. 1 at 104; Ex. A17 at 4-6.)

11. In the case of Patient G, Licensee found the cause of death was "rupture of container of illegal drug in stomach." According to Dr. Propst, rupture of a container of drugs is not a cause of death; it is an overdose of drugs that causes death. In Dr. Propst's opinion, the autopsy report does not support a cause of death determination of a drug overdose. Although Licensee noted that he took bile, gastric and blood samples, the report did not contain the results of toxicological tests on those samples. (Dr. Propst; tr. 1 at 105-107; Ex. A17 at 7; Ex. A16 at 7-10.)

12. In the case of Patient H, Licensee's report found the cause of death was myocardial infarction, old and recent. In Dr. Propst's opinion, Licensee should have microscopically examined the heart to verify a recent myocardial infarction. (Dr. Propst, tr. 1 at 107-108; Ex. A17 at 11-14.)

13. Patient I was found in a very decomposed state. In that case, Licensee found that the cause of death was a myocardial infarction. In Dr. Propst's opinion, Licensee should not have identified the body with a driver license, but should have documented his method of identification in the report. Licensee should also have microscopically studied the heart to determine the disease process and asked for toxicological tests. Dr. Propst believes that, without toxicological tests, Licensee should not have ruled out drug overdose as the cause of death. (Dr. Propst, tr. 1 at 108-110; Ex. 17 at 15-17.)

14. In the case of Patient J, Licensee found the cause of death was drowning, secondary to a farm accident. In Dr. Propst's opinion, Licensee should have microscopically examined the lungs, which should always be done where the suspected cause of death is drowning. The Board also notes that Licensee's report states that "both lungs are heavier than normal." Dr. Propst testified that Licensee should have weighed the lungs and conducted a microscopic study, particularly in view of Licensee's comment that the deceased smelled of diesel fuel. Dr. Propst does not believe that the cause of death determination was supported by the evidence listed in the autopsy report. (Dr. Propst, tr. 1 at 111-112; Ex. A17 at 18-20.)

15. In the case of Patient K, Licensee found the cause of death was acute myocardial infarction. Dr. Propst concluded that the cause of death was atherosclerotic coronary artery disease, which may have manifested itself as a myocardial infarction. Dr. Propst believes that Licensee should have microscopically examined the heart to confirm this. The Board notes that Dr. Propst also commented that Licensee failed to weigh the heart and other internal organs. (Dr. Propst; tr. 1 at 113; Ex. A19 at 5-7.)

16. In the case of Patient L, Licensee found the cause of death was complications of diabetes and methamphetamine abuse. In Dr. Propst's opinion, Licensee should have ordered toxicological tests. Patient L was also found with two small bruises on his forehead that Licensee should have investigated. (Dr. Propst; tr. 1 at 115-116; Ex A. 19 at 8-10.)

17. In the case of Patient M, Licensee found the cause of death was myocardial infarction. In Dr. Propst's opinion, Licensee should have microscopically examined the heart, liver, kidney and lungs. Licensee also diagnosed benign prostatic hyperplasia without microscopic examination. (Dr. Propst, tr. 1 at 116-117; Ex. A19 at 11-13.)

18. In the case of Patient N, Licensee found the cause of death was an overdose of antidepressant medication and alcohol. In Dr. Propst's opinion, Licensee should have provided supporting facts to confirm his cause of death determination. (Dr. Propst; tr. 1 at 117; Ex. A19 at 14-16.)

19. In regard to Patient O, a case not mentioned in the ALJ's review of the testimony by Dr. Propst, Licensee's list of pathologic diagnoses for this 30 year old female included marfanoid habitus and mitral valve prolapse with left ventricular hypertrophy. Dr. Propst criticized Licensee's failure to measure the length of the body or the length of the arms, failure to weigh the heart and to take sections of the myocardium for study. (Dr. Propst, tr. 1 at 118-119.)

20. In the case of Patient P, Licensee found the cause of death was blood loss. In Dr. Propst's opinion, Licensee should have weighed the heart and microscopically examined the heart and liver because he found them enlarged but offered no explanation for this. Dr. Propst believes that microscopic examination would have revealed the reason for the enlarged organs. (Dr. Propst; tr. 1 at 119; Ex. A19 at 21-24.)

21. In the case of Patient Q, who was found in a decomposing state, Licensee noted a gunshot wound in the right temple and diagnosed acute depression. In Dr. Propst's opinion, Licensee should have noted the circumstances of death and explained the method for identifying the body. Depression is not an appropriate pathologic diagnosis. (Dr. Propst, tr. 1 at 119-121; Ex. A19 at 21-24.)

22. In the case of Patient R, Licensee found the cause of death was hemorrhagic pancreatitis even though he does not mention examining the pancreas in the autopsy report. Dr. Propst believes that Licensee should have removed and examined Patient R's pancreas with a microscopic study. (Dr. Prospt, tr. 1 at 121-22; Ex A19 at 26-28.)

23. In the case of Patient S, Licensee found that the cause of death was a drug and alcohol overdose. In Dr. Propst's opinion, Licensee should have made findings to support this conclusion. Licensee also did not microscopically study the liver even though he diagnosed an alcoholic fatty liver. (Dr. Propst, tr. 1 at 123; Ex. A19 at 29-31.)

24. In Dr. Propst's opinion, inaccurate or incomplete autopsy reports pose a risk to public health and may compromise the state's ability to pursue and close criminal cases. (Dr. Propst; tr. 1 at 125.) The Board concurs with Dr. Propst that in 19 out of the 20 cases under review, Licensee ignored some standard practices in pathology; to including failing to measure the deceased (Licensee relied upon unreliable sources of data, such as driver's licenses), estimating the weights of the internal organs (instead of weighing them), relying upon gross examinations to formulate a cause of death (instead of also conducting microscopic studies, in cases where the cause of death involved myocardial infarction or a possible infectious disease), and attributing the cause of death to drug overdose without taking appropriate samples for toxicological studies. Even on the few occasions when samples were taken, Licensee failed to annotate the report to confirm or identify the presence of chemical substances in the body.

25. Sally Aiken, M.D., is a physician licensed to practice in Washington. She is currently the chief medical examiner in Spokane County, Washington. Dr. Aiken is familiar with national autopsy standards. Pursuant to the 2003 Order, Licensee asked Dr. Aiken to review five of the 20 autopsy reports. Dr. Aiken reviewed autopsies for Patient A, Patient B, Patient C, Patient D, and Patient E. (Dr. Aiken, tr. 2 at 8.)

26. Regarding Patient A, where Licensee concluded the cause of death was pneumonia, Dr. Aiken believes that Licensee should have done a microscopic examination to rule out other communicable diseases such as tuberculosis. Dr. Aiken also believes that Licensee should have done microscopic studies of Patient E and Patient D and that his estimates of body organs were inaccurate. (Dr. Aiken, tr. 2 at 11-13.) The Board notes that Dr. Aiken also commented unfavorably on Licensee's practice of estimating organ weights, and noted that portable electronic scales are readily available, and are both affordable and accurate.

27. Marco Ross, M.D., is physician licensed to practice in Washington. He is a forensic pathologist with the Spokane County Medical Examiner's Office. Dr. Ross is familiar with national autopsy standards. Pursuant to the 2003 Order, Licensee asked Dr. Ross to review five of the 20 autopsy reports. Dr. Ross reviewed autopsies for Patient F, Patient G, Patient H, Patient I and Patient J. In those cases, in Dr. Ross' opinion, Licensee should have microscopically examined tissues. Dr. Ross also believes that, where Licensee determined that the cause of death was a drug overdose, toxicological tests should have been requested and the results noted in the autopsy report. (Dr. Ross, tr. 2 at 24-27.)

28. Karen Gunson, M.D., is a physician licensed to practice in Oregon. She is familiar with national and Oregon autopsy standards. She has served as the State Medical Examiner for Oregon since 1999. She has served on the Board of Directors for the National Association of Medical Examiners for six years and on their Executive Committee for three years. Pursuant to the 2003 Order, Licensee asked Dr. Gunson to review 10 of the 20 autopsy reports. Dr. Gunson testified that Licensee failed to meet the standard of care and to protect the public health by failing to conduct microscopic examinations in appropriate cases, such as when pus was noted

on the gross examination to be exuding from the lungs (Patient A). This could lead to a missed diagnosis of an infectious disease, such as tuberculosis. Licensee also failed to conduct a microscopic study of relevant heart tissue to confirm and date the myocardial infarction, such as in the cases of Patient D and Patient E. In these cases, Licensee stated the cause of death to be myocardial infarction based upon his gross examination. A microscopic study allows a pathologist to confirm this diagnosis and to be specific about the time that a myocardial infarction occurred. (Dr. Gunson, tr. 3, 48.) Additionally, Licensee breached the standard of care by relying upon information listed on driver licenses (an unreliable source of information) rather than using a tape measure to measure the height of the deceased, and he consistently estimated the weight of body organs rather than weigh the organs on portable scales. (Dr. Gunson, tr. 2 at 38, 57-60; tr. 3 at 20-21, 28.) Dr. Gunson also criticized Licensee for failing to take blood and urine samples and failing to send them to the toxicology laboratory at the State Medical Examiner's Office for analysis. And on the occasions where samples were taken, Licensee failed to annotate the autopsy report with the results of the toxicology studies. (Dr. Gunson, tr.2 at 44-48, 82.) Dr. Gunson terminated Licensee as the Klamath County Medical Examiner on December 31, 2005.

29. Matthias Okoye, M.D., is a physician licensed to practice in Nebraska. He specializes in forensic medicine. He was the former Chief Medical Examiner for the District of Columbia for two years (under Mayor Marion Berry) and then moved to Nebraska, where he is a clinical associate professor at Creighton University. Dr. Okoye is familiar with national autopsy standards. He is also a licensed attorney. He was retained by Licensee to review the 20 autopsy reports and serve as a forensic consultant for the defense. In Dr. Okoye's opinion, microscopic studies are not needed for most autopsies. Dr. Okoye agreed with Licensee's cause of death determination in all 20 cases. He also testified that microscopic examinations were not required in the 20 cases that he reviewed and would not "lend more in terms of accuracy of the pathologic diagnoses or accuracy in the causation of death and also manner of death." (Dr. Okoye, tr. 3 at 34-91.) The Board also notes that Dr. Okoye believes that a reasonably competent pathologist can estimate internal organ weight and it is within the standard of care to do so. He also opined that Licensee met the standard of care in regard to toxicology. He concluded that overall, Licensee's autopsy reports conformed to the standard of care.

Nuclear Medicine Practice

30. The Board received a complaint about Licensees' nuclear medicine practice and began an investigation in June 2006. (Ex. A4.)

31. Gary Gates, M.D. is a physician licensed to practice in Oregon. He is the former director of the Providence St. Vincent nuclear medicine department and board-certified in radiology and nuclear medicine. Dr. Gates is currently a clinical professor of nuclear medicine at Oregon Health Sciences University. He is familiar with the standard of care for nuclear medicine in Oregon. (Dr. Gates, tr. 1 at 144-146.)

32. At the Board's request, Dr. Gates reviewed 27 of Licensee's nuclear medicine cases where Licensee interpreted the results of cardiac, whole body, bone and thyroid

scans. Dr. Gates generally found that Licensee did not meet the standard of care for nuclear medicine. (Dr. Gates, tr. 1 at 147.)

33. In case numbers 174258 and 128141, the patients had thyroid scans. Based on the scans, Licensee diagnosed goiter, a condition characterized by an enlarged thyroid gland. In Dr. Gates' opinion, these were not correct diagnoses because the size of the thyroid can be adjusted during the scan. According to Dr. Gates, goiter should be detected by feeling the patient's neck. In case number 174258, Licensee reported that the thyroid appeared normal during the physical examination, which would be inconsistent with a diagnosis of goiter. And, he reported normal values for thyroid uptake when they were actually abnormal. In case number 128141, Licensee did not do a physical examination for goiter. (Dr. Gates, tr. 1 at 150-152, 163-164; Ex. A23 at 1, 24.)

34. In case number 274724, the patient had a hepatobiliary scan, which is used to study liver function. Licensee diagnosed common bile duct obstruction, a very serious condition often requiring immediate surgical intervention. In Dr. Gates' opinion, Licensee misdiagnosed the patient. Neither Licensee's examination of the patient nor the scan revealed any evidence of common bile duct obstruction. Had there been a bile duct obstruction, it would have appeared on the scan. (Dr. Gates: tr. 1 at 155-157; Ex. A23 at 9.)

35. In case number 135975, the patient had a hepatobiliary scan. Dr. Gates agreed with Licensee's conclusion that the patient's gallbladder function was normal but believes that Licensee should have noted the patient's gastric reflux because the patient presented with epigastric pain. (Dr. Gates, tr. 1 at 158-159; Ex. A23 at 34.)

36. In case number 116429, the patient had a hepatobiliary study. Dr. Gates agreed with Licensee's conclusion that the gallbladder contracted normally but disagrees with Licensee's conclusion that the gallbladder was small and slow-filling. This conclusion could result in unnecessary further testing or surgery. (Dr. Gates, tr. 1 at 162; Ex. A23 at 17.)

37. In case number 110627, the patient had a heart scan. The patient had a history of coronary artery disease, had bypass surgery in the past and presented with neck pain. Licensee concluded that the patient's neck pain was not the result of heart disease and that certain values were essentially normal. In Dr. Gates' opinion, those values were abnormal, could signal a coronary disease process and should have been noted in the report to the treating physician. (Dr. Gates, tr. 1 at 169-170; Ex. A23 at 5.)

38. In case numbers 105337 and 222590, the patients had bone scans. In the first case, the patient presented with leg pain and has a prosthetic knee joint. In Dr. Gates' opinion, loosening of the prosthesis can cause pain. Licensee did not consider this and diagnosed the activity in the knee as degenerative or arthritic changes. Prosthetic devices do not undergo such changes. In the second case, Licensee reported the results of the scan as normal. In Dr. Gates' opinion, because the joint in question had

been surgically altered, the results should have been reported as abnormal. (Dr. Gates, tr. 1 at 173-176; Ex A23 at 6-7.)

39. In case number 199979, the patient had a bone scan for a suspected lesion on the pelvis. Licensee diagnosed a compression fracture. In Dr. Gates' opinion, the patient had degenerative disc disease because the abnormality clearly appears on the scan confined to the disc area of the spine. (Dr. Gates, tr. 1 at 177-178; Ex A23 at 8.)

40. In case number 250117, the patient had a lung scan. Licensee noted the presence of fluid in the lungs and an enlarged heart and diagnosed heart failure. In Dr. Gates' opinion, Licensee misdiagnosed the patient because fluid in the lungs and an enlarged heart do not always mean that a patient has congestive heart failure. Dr. Gates also believes that further testing is required to diagnose congestive heart failure. (Dr. Gates; tr. 1 at 180-181; Ex A23 at 16.)

41. David Shelton, M.D., is a physician licensed to practice in California. He specializes in radiology and nuclear medicine. At Licensee's request, Dr. Shelton reviewed the 27 nuclear medicine cases. In Dr. Shelton's opinion, Licensee met the standard of care in all the cases that he reviewed. (Dr. Shelton, tr. 4 at 55, 69.)

CONCLUSIONS OF LAW

1. Licensee engaged in dishonorable and unprofessional conduct in his forensic and nuclear medicine practices in violation of ORS 677.190(1)(a), as defined in ORS 677.188(4)(a) and gross or repeated acts of negligence in violation of ORS 677.190(14).

2. The ALJ proposed that an appropriate sanction includes revocation and assessment of the costs of the hearing as a civil penalty. The Board notes that the assessment of costs and a civil penalty are separate and distinct.

OPINION

The Board proposes to take disciplinary action against Licensee pursuant to ORS 677.205 for violations of the Medical Practice Act. The Board has the burden of proving its allegations, and Licensee has the burden to prove any affirmative defenses. ORS 183.450(2); *Gallant v. Board of Medical Examiners,* 159 Or App 175, 183 (1999).

The Board maintains that Licensee violated the Medical Practice Act in his forensic and nuclear medicine practices and that his license to practice medicine should be revoked.

The Medical Practice Act set out in ORS 677.205 authorizes the Board to discipline a physician who is found in violation of one or more of the grounds for disciplinary action. In this case, the Board bases its action on the following provisions of ORS 677.190.

(1)(a) Unprofessional or dishonorable conduct.
* * *
(14) Gross negligence or repeated negligence in the practice of medicine or podiatry[.]

For purposes of ORS 677.190(1)(a), the definition of "unprofessional or dishonorable conduct" is set out at ORS 677.188(4). It provides, in relevant part:

> 'Unprofessional or dishonorable conduct' means conduct unbecoming a person licensed to practice medicine or podiatry, or detrimental to the best interests of the public, and includes:
>
> (a) Any conduct or practice contrary to recognized standards of ethics of the medical or podiatric profession or any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public or any conduct, practice or condition which does or might impair a physician's or podiatric physician and surgeon's ability safely and skillfully to practice medicine or podiatry.

Forensic Practice

There are significant differences of opinion regarding Licensee's autopsies. Drs. Propst, Gunson, Aiken, and Ross, who testified for the Board, found significant deficiencies in the 20 autopsy reports submitted by Licensee. Dr. Okoye, who testified on behalf of Licensee, disagreed with all of their conclusions. The ALJ noted that all five physicians are familiar with national autopsy standards but only Drs. Propst and Gunson were familiar with Oregon standards. The Board does not believe that the standards in Oregon for the conduct of autopsies deviate from the national standards and therefore does not base its credibility determination upon the Oregon experience of these witnesses. The testimony of Drs. Propst, Gunson, Ross and Aiken support that Licensee repeatedly failed to meet the standard of care for autopsies. Licensee initially asked Drs. Ross and Aiken to review his reports pursuant to the 2003 Final Order. They provided an unbiased, objective perspective in regard to the 10 autopsy reports that they reviewed. Dr. Propst testified as the Board's consultant, and Dr. Gunson was identified as a reviewer by virtue of her position as State Medical Examiner. Although Dr. Okoye, the defense consultant, received financial remuneration for his testimony, that is to be expected and the Board does not discount his testimony because of this, or that he came from an out of state location. The ALJ was not persuaded that his opinion was as objective as those of the Board's witnesses. Consequently, the ALJ gave greater weight to the opinions offered by the Board's witnesses. The Board agrees, based upon the content of Dr. Okoye's testimony in contrast to the testimony of Drs. Propst, Aiken, Ross and Gunson, together with the Board's own review of the autopsy reports. The Board, therefore, agrees with the ALJ's conclusion that the weight of the evidence established that Licensee was repeatedly negligent in his forensic practice, as shown in 19 of the 20 autopsy reports, and should be disciplined under ORS 677.205.

In contrast to the ALJ's perspective, the Board is of the opinion that there is a national standard of care for pathology that applies in Oregon. Therefore, the Board does not discount the testimony of any witness because they have not practiced in Oregon. The Board, however, is persuaded by the testimony of Drs. Propst, Gunson, Aiken and Ross that Licensee repeatedly breached the standard of care in the autopsy reports under review. The Board is persuaded by their testimony that the standard of care requires that an autopsy must include microscopic examination to confirm and date myocardial infarctions and to look for the

presence of infectious disease in appropriate cases. In addition, toxicology studies should be conducted and the results annotated to the autopsy report when the presence of drugs is suspected or is listed as a cause of death. In contrast, only Dr. Okoye supported Licensee in his practice of not weighing body organs, not conducting microscopic studies and failing to ensure that toxicology studies were done and annotated to the report. Therefore, his opinion is not credible—that Licensee's conduct conformed to the standard of care for a pathologist. In the Board's opinion, Licensee failed to conform to the standard of care when he repeatedly reported estimated internal organ weights, failed to conduct microscopic studies to confirm his diagnosis, and failed to either initiate or report toxicology studies.

The Board also notes that although the ALJ failed to address the case of Patient T, the case did not support a finding of negligence. Although Dr. Propst testified that Licensee improperly failed to state the circumstances of death in his reports (Dr. Propst, tr. 1 at 123), Dr. Gunson, the State Medical Examiner, did not find this to be a breach of the standard of care, and neither did any of the other pathologists criticize this aspect of Licensee's reports. Therefore, the Board does not fault Licensee for failing to set forth the circumstances of death in any of the reports under review.

Nuclear Medicine Practice

There are also significant differences of opinion regarding Dr. Edwards' nuclear medicine practice. After reviewing 27 of Licensee's nuclear medicine cases, the Board's witness, Dr. Gates, concluded that Licensee repeatedly failed to meet the standard of care. Dr. Shelton, who testified for Licensee, concluded to the contrary. The ALJ commented that Dr. Gates is familiar with the standard of care for nuclear medicine in Oregon while Dr. Shelton is not. More significantly for the Board, Dr. Shelton appeared to have been influenced by his 10 years of acquaintance with Licensee, and had a preconceived opinion that the Board had conducted a "skewed" study, in that he had assumed that the Board had selected 27 problem cases for review. Instead, the Board had drawn 27 cases randomly for review from a total of 193 nuclear medicine studies conducted by Licensee for 2003 from Merle West Hospital. (Tr. 4 at 100-101.) The ALJ noted that in case number 105337, Licensee reported a degenerative or arthritic disease process in a prosthetic knee. Even to a lay person, the ALJ found this to be an obvious mistake and casts doubt on Dr. Shelton's opinion that Licensee consistently met the standard of care. The Board also notes that Dr. Shelton's testimony was nuanced, and that he took pains to offer only the mildest of criticisms towards Licensee's studies, to include commenting upon Licensee's failure to palpate the thyroid gland or to comment on the size of the thyroid, which nevertheless supported Dr. Gates' opinion in regard to 128141. In regard to case 174258, Dr. Shelton conceded that the study did show mild elevations of thyroid hormones, which would be an indication of hyperthyroidism and compatible with Graves disease. (Tr. 4 at 106-107). Again, when pressed, he essentially agreed with Dr. Gates, but he was quick to volunteer a rationale "in Licensee's defense." (Tr. 4 at 107.) Dr. Shelton also attributed some of Dr. Gates' criticisms to "grey areas" in the practice. The Board is more persuaded by the expertise, greater objectivity and testimony of Dr. Gates and is less persuaded by the testimony of Dr. Shelton. The Board therefore agrees with the ALJ's ultimate conclusion to give greater weight to Dr. Gates' opinion. As a result, the Board concludes that the weight of the evidence establishes that Licensee was repeatedly negligent in his nuclear medicine practice, as shown by the review of the 27 nuclear medicine cases in this record, and that Licensee should therefore be

disciplined under ORS 677.205 for his repeated acts of negligence in regard to the nuclear medicine studies, in addition to his deficient autopsy reports.

Sanction

The Board proposed at hearing to discipline Licensee by revoking his license and assessing the costs associated with the hearing. Licensee contends that his license should not be revoked. He did not dispute the assessment of costs at the hearing.

In August 2003, the Board revoked Licensee's license to practice for repeated acts of negligence in his cytology and forensic practices. The Board stayed the revocation and imposed certain conditions. But, even after the order was issued, Licensee was repeatedly negligent in both his forensic and nuclear medicine practices. The ALJ noted that the Board's prior discipline did not appear to have been effective. The ALJ found that the Board has established that Licensee's failure to conduct microscopic examinations during autopsies and his incorrect interpretations of nuclear medicine studies pose a significant risk to public health. The Board agrees, and notes that at the hearing, Licensee failed to take responsibility for his own practice shortcomings, and that any further attempt to educate, monitor or restrict his practice under additional terms of probation would be an exercise in futility and only subject the public to substandard practice habits. Consequently, the Board adopts the ALJ's recommendation to revoke the license of Licensee to practice medicine and to assess costs.

EXCEPTIONS FILED BY LICENSEE

Licensee filed exceptions with the Board through his counsel on January 4, 2008. Licensee decries that it took nearly 8 months for ALJ Halpert to release his proposed order. The Board is concerned with the significant lapse of time that it took this ALJ to render his opinion, but believes that Licensee has been afforded sufficient time to submit his written exceptions on January 4, 2008 and to appear before the Board (through counsel on January 10, 2008).

Licensee contends that the ALJ gave undue weight to the Board's experts while minimizing or ignoring the testimony offered by Dr. Okoye, Dr. Shelton and the declaration by Dr. Wickham. Licensee urges the Board to "more carefully consider Dr. Okoye's testimony...." The Board has reviewed the record, to include the verbatim transcript of the hearing, and has found the testimony of the four pathologists called to testify by the Board's counsel to be more persuasive than the testimony presented on behalf of Licensee. Drs. Propst, Gunson, Aiken and Ross were largely in agreement in regard to their critique of the autopsy reports prepared by Licensee, in his failure to conduct microscopic and toxicology studies in appropriate cases, and his failure to weigh body organs. They all agreed that Licensee had breached the standard of care in preparing the autopsy reports under review.

Licensee also takes exception to the ALJ's reliance upon the testimony of Dr. Gates instead of Dr. Shelton. The Board has reviewed the record, and for reasons previously stated, agrees with the ALJ that Dr. Gates was the more credible witness and his testimony more persuasive.

Licensee further contends that the ALJ was speculating that Licensee posed "a significant risk to public health." The weight of the evidence supports the findings of fact and conclusion of law set forth above. Licensee misdiagnosed multiple nuclear medicine studies and negligently conducted 19 out of 20 autopsies while on probation. His consistent failure to conduct the necessary microscopic and toxicological studies, even with evidence of possible infectious diseases, myocardial infarction or suspected drug overdose (or to report such studies) highlight once again Licensee's propensity to practice medicine in a slip shod fashion. The Board's effort to protect the public by placing Licensee on probation has failed. The only way to adequately protect the public is to remove Licensee from the practice of medicine.

FINAL ORDER

The Board imposes the following sanctions:

1. The license of Robert Norfleet Edwards, Jr. to practice medicine in the state of Oregon is revoked.

2. Licensee shall be assessed the costs associated with the hearing. The Board directs that Licensee will pay the costs in full within 90 days from the date the Board issues the "Bill of Costs."

DATED this 7th day of Feb, 2008.

OREGON MEDICAL BOARD
State of Oregon

PATRICIA L. SMITH
BOARD CHAIR

Right to Judicial Review

NOTICE: You are entitled to judicial review of this Order. Judicial review may be obtained by filing a petition for review with the Oregon Court of Appeals within 60 days after the final order is served upon you. See ORS 183.482. If this Order was personally delivered to you, the date of service is the day it was mailed, not the day you received it. If you do not file a petition for judicial review within the 60 days time period, you will lose your right to appeal.